

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11369

CERTIFICATE OF DEATH

11354

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. LENGTH OF STAY IN 1b 1084 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	Firs Gentruude	Middle F.	Last Billmyer
4. DATE OF DEATH	Month 10	Day 25	Year 1961
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-3-1871
9. AGE (In years less birthday) 90 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY House hold	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Wilhelmn Ritter	14. MOTHER'S MARRIED NAME Katherine Schanze		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. 220-20-2892 B	17. INFORMANT Record of Victor Cullen Hosp.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 0092X		INTERVAL BETWEEN ONSET AND DEATH 6 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Arteriosclerosis - 450			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/6 to 10/25 , 1961, that (I) (we) last saw the deceased alive on 10/25 , 1961, and that death occurred at 11:58 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Michael S. Zavis		22b. DATE SIGNED 10/25/61	
22c. PHYSICIAN'S NAME (Type) Michael S. Zavis	22d. ADDRESS Cullen, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-28-61	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem.	23d. LOCATION (City, town, or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Raymond L. Bragan	ADDRESS Thurmont, Md.	25a. REC'D BY REGISTRAR DATE OCT 27 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Krause

— 36 —

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11370

CERTIFICATE OF DEATH

Reg. Dist. No.

11355

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		c. LENGTH OF STAY IN 1b 3 years		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Middletown		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First George	Middle Raymond	Lost Bowers	4. DATE OF DEATH	Month 10	Doy 12	Year 61 19
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/1894		9. AGE (In years lost birthday) 67 yr.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Dys	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm owner		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME George W. Bowers			14. MOTHER'S MAIDEN NAME Ella F. Moore			Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Charlotte Bowers, Middletown, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Bronchogenic Carcinoma left Lung		INTERVAL BETWEEN ONSET AND DEATH 7 mos				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Metastasis to Brain				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)
21. I certify that I attended the deceased from <u>June</u> , 1961, to <u>Oct 12</u> , 1961, that I last saw the deceased alive on <u>Oct 12</u> , 1961, and that death occurred at <u>4501 M</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>J Elmer Harp</i> M.D.								(State)
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/15/1961		22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery		22d. LOCATION (City, town, or county) Middletown, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE Oct 17 '61		24b. REGISTRAR'S SIGNATURE <i>Elmer S. Harp</i>		

CERTIFICATE OF DESIGN

0255

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3 1
FOR STATE
HEALTH DEPT.

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TO FUNERAL DIRECTOR: Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11371 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11356

1. PLACE OF DEATH a. COUNTY Frederick	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown	c. LENGTH OF STAY IN 16 7 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown	d. STREET ADDRESS 213 Jefferson St.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 213 Jefferson St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Howard	First Elwood	4. DATE OF DEATH Last Bowie	Month 10		
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	Day 16		
		8. DATE OF BIRTH 3/4/1900	Year 19 61		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY garage	9. AGE (In years last birthday) 61 yrs.	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Bowie	14. MOTHER'S MAIDEN NAME Evelyn Liaison	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or dates of service) no	16. SOCIAL SECURITY NO. 217-10-0832	17. INFORMANT Mrs. Edith Bowie, Middletown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH minutes					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B. O. Thomas	CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED Oct. 16, 1961
EXAMINER'S NAME (Type) Dr. B. O. Thomas	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 10/18/1961	22c. NAME OF CEMETERY OR CREMATORIAL Reformed Cemetery	22d. LOCATION (City, town, or country) Middletown, Md.	(State)	
23. FUNERAL DIRECTOR Gladhill Company, Middletown, Md.	ADDRESS	24a. REC'D BY REGISTRAR OCT 17 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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069

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11357

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Since 9/29/61	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First GOLDYE	Middle MAE	Last BRANDENBURG
4. DATE OF DEATH October 8, 1961	Month October	Day 8	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 22 March 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Clerk		10b. KIND OF BUSINESS OR INDUSTRY Pastry Shop	11. BIRTHPLACE (County & State, or foreign country) Kempton, Maryland
13. FATHER'S NAME Oscar M. Brandenburg		14. MOTHER'S MAIDEN NAME Mary Jane Baker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-26-5483	17. INFORMANT Glenn H. Brandenburg (Same as item #2)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 572.3		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause first. } (b)		DUE TO	
} (c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour e.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 1, 1950 to Oct. 8, 1961 , that (I) (we) last saw the deceased alive on Oct. 8, 1961 , and that death occurred 5:40 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 10 Oct 1961	
22e. SIGNATURE <i>B. O. Thomas</i>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) B. O. Thomas, M. D.		22d. ADDRESS 228 N. Market St., Frederick, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 10-11-61	23c. NAME OF CEMETERY OR CREMATORIAL Providence Cemetery	23d. LOCATION (City, town or county) Kempton, Md. (State)
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Md.		ADDRESS M. R. Etchison & Son, Frederick, Md.	25a. REC'D BY REGISTRAR DATE OCT 11 '61
			25b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>

STCLL

M

Overall description

Acrylic paint

Acrylic paint

1. Materials and methods

2. Results and discussion

3. Conclusions

4. Acknowledgments

5. References

6. Author biography

7. Author biography

8. Author biography

9. Author biography

10. Author biography

11. Author biography

12. Author biography

13. Author biography

14. Author biography

15. Author biography

16. Author biography

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11373

CERTIFICATE OF DEATH

11358

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) b. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b Lifetime			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Monocacy Hall Nursing Home			d. STREET ADDRESS 407 East Patrick St.					
3. NAME OF DECEASED (Type or print) Anna Rosetta Burger			First Anna	Middle Rosetta	Last Burger			
5. SEX Female			6. COLOR OR RACE White			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> May 5-1871		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Frederick County- Maryland		
13. FATHER'S NAME Wm. Henry Burger			14. MOTHER'S MAIDEN NAME Anna Margaretha Drarer			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No			16. SOCIAL SECURITY NO.			17. INFORMANT Mr. W. Leslie Burger- Culler Ave.-Frederick-Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Myocardial Enfarct 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 2-3pm		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 2Dd. INJURY OCCURRED p.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20d. (City or town) (County) (State) 20e. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan. 10, 1961 , to Oct. 29, 1961 , that (I) (we) last saw the deceased alive on Oct. 28, 1961 , and that death occurred at 5:15A from the causes and on the date stated above.			22. SIGNATURE B.O.Thomas M.D.			22b. DATE SIGNED 10/30/61		
22c. PHYSICIAN'S NAME (Type) Dr. B.O.Thomas-Sr.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Professional Bldg.- Frederick- Md.			23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Oct. 31-1961 23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		
24. FUNERAL DIRECTOR'S SIGNATURE Dailey's Funeral Home- Frederick- Md.			ADDRESS by E.J. Whitmore			23d. LOCATION (City, town or county) (State) Frederick- Md.		
25e. REC'D BY REGISTRAR NOV 2 '61			25b. REGISTRAR'S SIGNATURE Clinton S. Kraus					

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SOLVENT-ADSORBED POLYMERS

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—*and I am not going to let you do that to me.* I said.

—Institute of Child Guidance—

420 *Journal of Health Politics, Policy and Law*

182 *Journal of Health Politics*

www.ohiostate.com/ohio-100/ohio-100-2012

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

M

11374

11359

1. PLACE OF DEATH

a. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

MARYLAND

Since 9/22/61

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Frederick Memorial Hospital

**3. NAME OF
DECEASED
(Type or print)**

First

Middle

MEDORA

IRENE

BURNS

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

DIVORCED

WIDOWED

8. DATE OF BIRTH

7 April 1896

10a. **USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)

House-work

10b. **KIND OF BUSINESS OR INDUSTRY**

At Home

11. **BIRTHPLACE** (County & State or foreign country)

Jefferson, Maryland

13. FATHER'S NAME

Unknown

15. **WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes, give rank and dates of service)

No

16. **SOCIAL SECURITY NO.**

212-03-4752

17. INFORMANT

Mrs. Alice N. Kabrick (Same as item #2)

Address

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Uremia

**INTERVAL BETWEEN
ONSET AND DEATH**

3 weeks

153.2

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Obstructing ureters by metastatic tumor

Carcinoma of descending Colon 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Generalized metastases from (c) above.

19. **WAS AUTOPSY PERFORMED?**

YES NO **X**

20a. **TIME OF INJURY**

Month, Day, Year
Hour a.m.
p.m.

20d. **INJURY OCCURRED**

While
at work Not While
at work

20a. **PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

20f. **(City or town)**

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

24/08/58 to **8 Oct 1961**, that (I) (we) last

saw the deceased alive on **8 Oct 1961**, and that death occurred **3:50P.M.** from the causes and on the date stated above.

22a. **SIGNATURE**

Charles H. Conley, Jr., M. D.

M.D.

**ATTENDING
PHYS.**

**MED.
DIRECTOR**

**STAFF
PHYS.**

22b. **DATE
SIGNED**

16 Oct 1961

22c. **PHYSICIAN'S
NAME (Type)**

Charles H. Conley, Jr., M. D.

22d. **ADDRESS**

228 N. Market St., Frederick, Md.

(State)

23a. **BURIAL, CREMATION, REMOVAL** (Specify)

Burial

23b. **DATE THEREOF**

10-11-61

23c. **NAME OF CEMETERY OR CREMATORIUM**

Mount Olivet Cemetery

23d. **LOCATION (City, town or county)**

Frederick, Md.

(State)

24. **FUNERAL DIRECTOR'S SIGNATURE**

M. R. Etchison & Son, Frederick, Md.

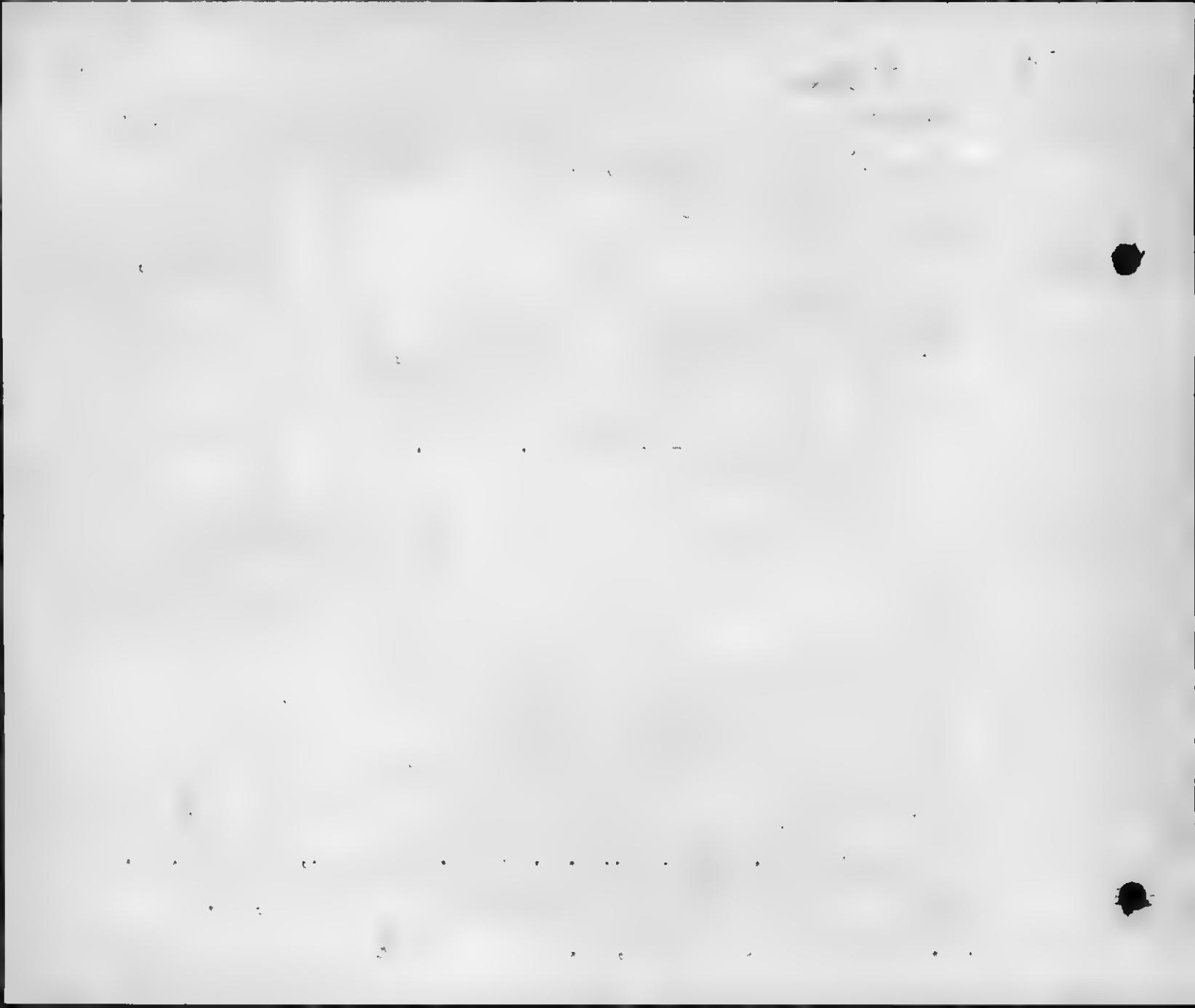
ADDRESS

25a. **REC'D BY REGISTRAR**

OCT 11 '61

25b. **REGISTRAR'S SIGNATURE**

Charles E. H. Conley





10. HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after Page 4 may be retained by the hospital or attending physician.

11. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11376

CERTIFICATE OF DEATH

11361

1. PLACE OF DEATH

a. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Memorial Hospital

MARYLAND

c. LENGTH OF STAY IN lb

3. NAME OF DECEASED
(Type or print)

Randy

First

Middle

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Frederick

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Brunswick

d. STREET ADDRESS

9 East 11th

Last

4. DATE
OF
DEATH

10

17

1961

Day

Year

e. IS RESIDENCE
ON A FARM?
YES NO

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

10-1-1961

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (County & State, or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Dawson

14. MOTHER'S MAIDEN NAME

Anna Forback

Address

Robert Dawson, Brunswick, Maryland

INTERVAL BETWEEN
ONSET AND DEATH
17 days

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a):

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause (b),

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

p.m.

While

Not While

at work

at work

20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20e. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 10-1-1961 to 10-17-1961, that (I) (was) last saw the deceased alive on 10-17-1961, and that death occurred at 10 PM, from the causes and on the date stated above.

22e. SIGNATURE

C. E. PRUITT

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
10-25-61

22d. ADDRESS

BRUNSWICK MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

10-18-61

23c. NAME OF CEMETERY OR CEMETORY

Park Heights

24. FUNERAL DIRECTOR'S SIGNATURE

B. H. Tule

ADDRESS

Brunswick, Maryland

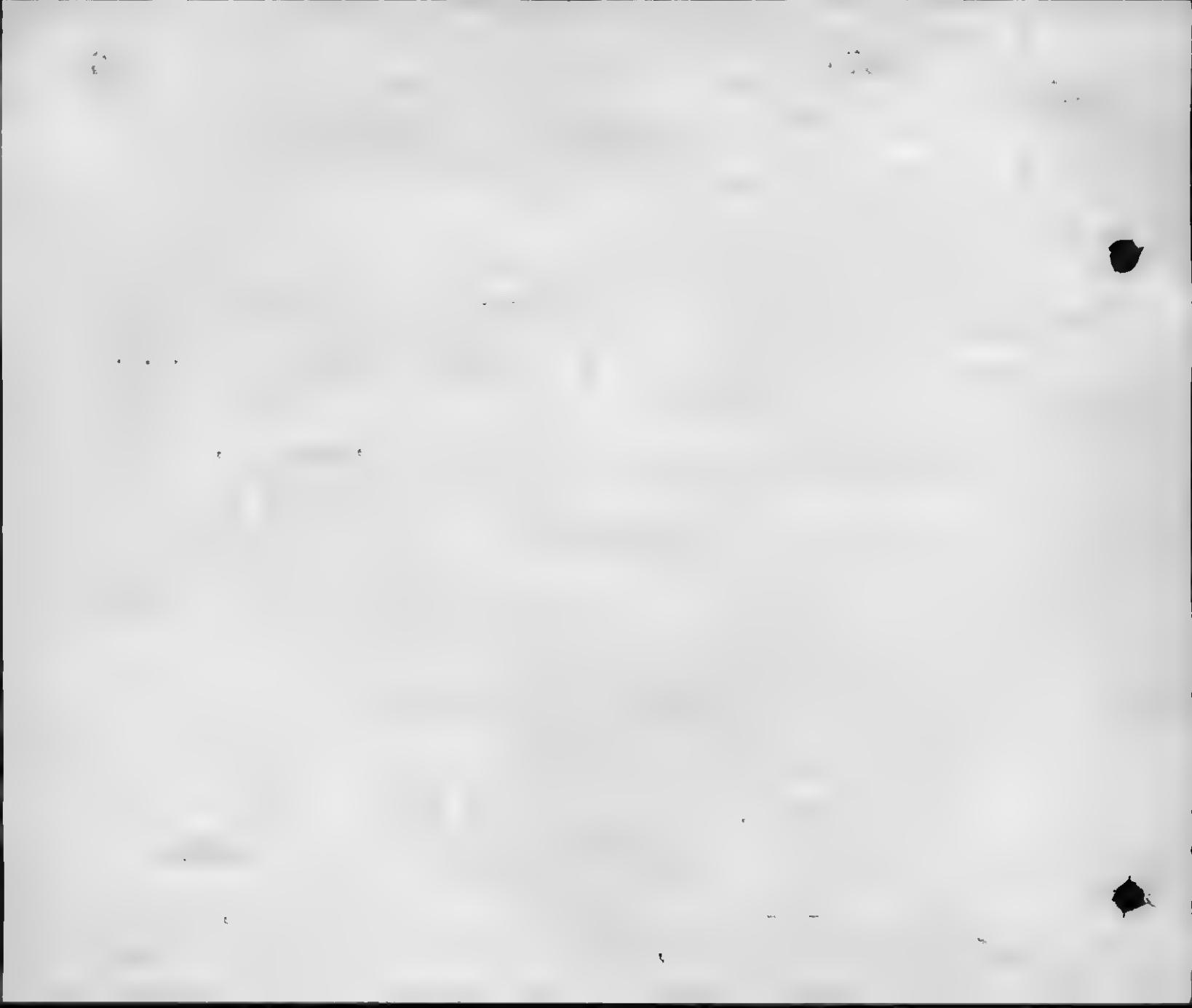
23d. LOCATION (City, town or county)

(State)

Brunswick, Maryland

25a. REC'D BY REGISTRAR
DATE OCT 27 '61

25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11362

11377

1. PLACE OF DEATH

a. COUNTY

FREDERICK

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

FREDERICK

c. LENGTH OF STAY IN lb

life

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

FRED, Mem. Hosp

3. NAME OF DECEASED
(Type or print)

First
Nina

Middle
Myra

Last
Derr

4. DATE OF DEATH

Oct

Month
12
Year
1961

5. SEX

Female

White

6. COLOR OR RACE

7. MARRIED **NEVER MARRIED**

WIDOWED **DIVORCED**

8. DATE OF BIRTH

May 25, 1880

**9. AGE (In years
last birthday)**

81 yrs.

IF UNDER 1 YEAR
Months
Days

IF UNDER 24 HRS
Hours
Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Frederick, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Albert J. Derr

14. MOTHER'S MAIDEN NAME

Mary C. Nuss

Address

Mrs. Zulma J. Derr 202 Dill Avenue Frederick,

MARYLAND

20 yrs

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

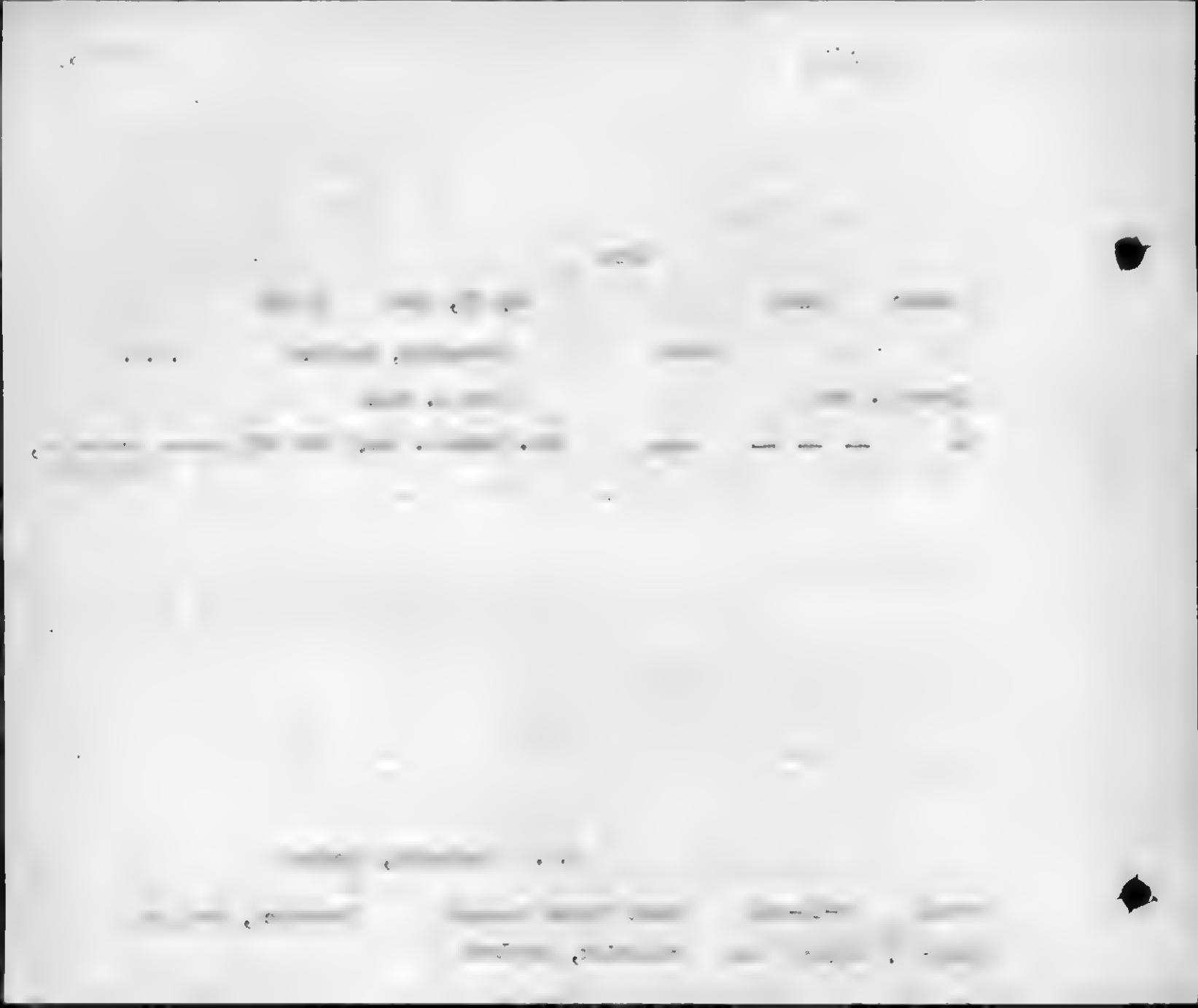
DUE TO

(b)

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

DUE TO

(c)



FOR STATE
HEALTH DEPT.

INSTITUTY MEDICAL DIRECTOR: This certificate should be executed within 24 hours after death. Execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent prior to burial or cremation, and in my absence, within 72 hours after death.

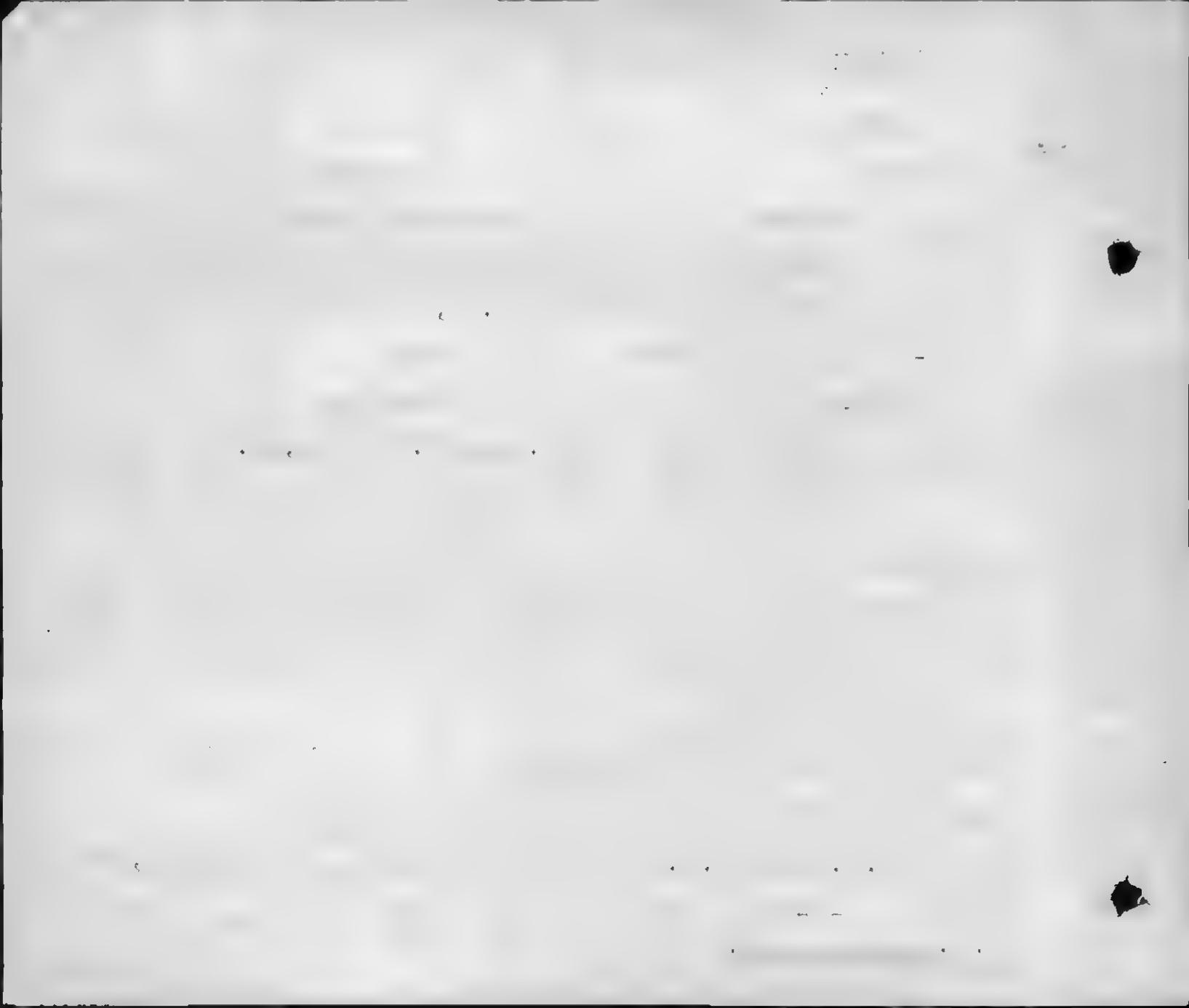
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11378 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11363

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Frederick		a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		b. COUNTY Frederick	
Frederick		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
117 East 6th Street		117 East 6th Street	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle		Last Month Day	
ELSIE		MAE DEVILBISS	
5. SEX		6. COLOR OR RACE	
Female		White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
House-work		at home	
10c. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Maryland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Fogle		Nettie Suman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes give rank or date of service)		17. INFORMANT	
No		Mr. George W. Devilbiss, Sr. (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Minutes	
Coronary Thrombosis			
420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
CAUSE OF DEATH.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED	
Hour a.m. 19		While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	
p.m.		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <i>B. O. Thomas</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		DATE SIGNED October 28, 1961	
22b. DATE THEREOF		Address (Street, city, town, or county)	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or country)	
Burial 10-31-1961 Mount Olivet Cemetery		(State)	
23. FUNERAL DIRECTOR M. R. Etchison and Son, Frederick, Maryland		24a. REC'D BY REGISTRAR NOV 1 '61	
By phone at home		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

V5. A15MB
5M 7/59



INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be retained within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial (transit) permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

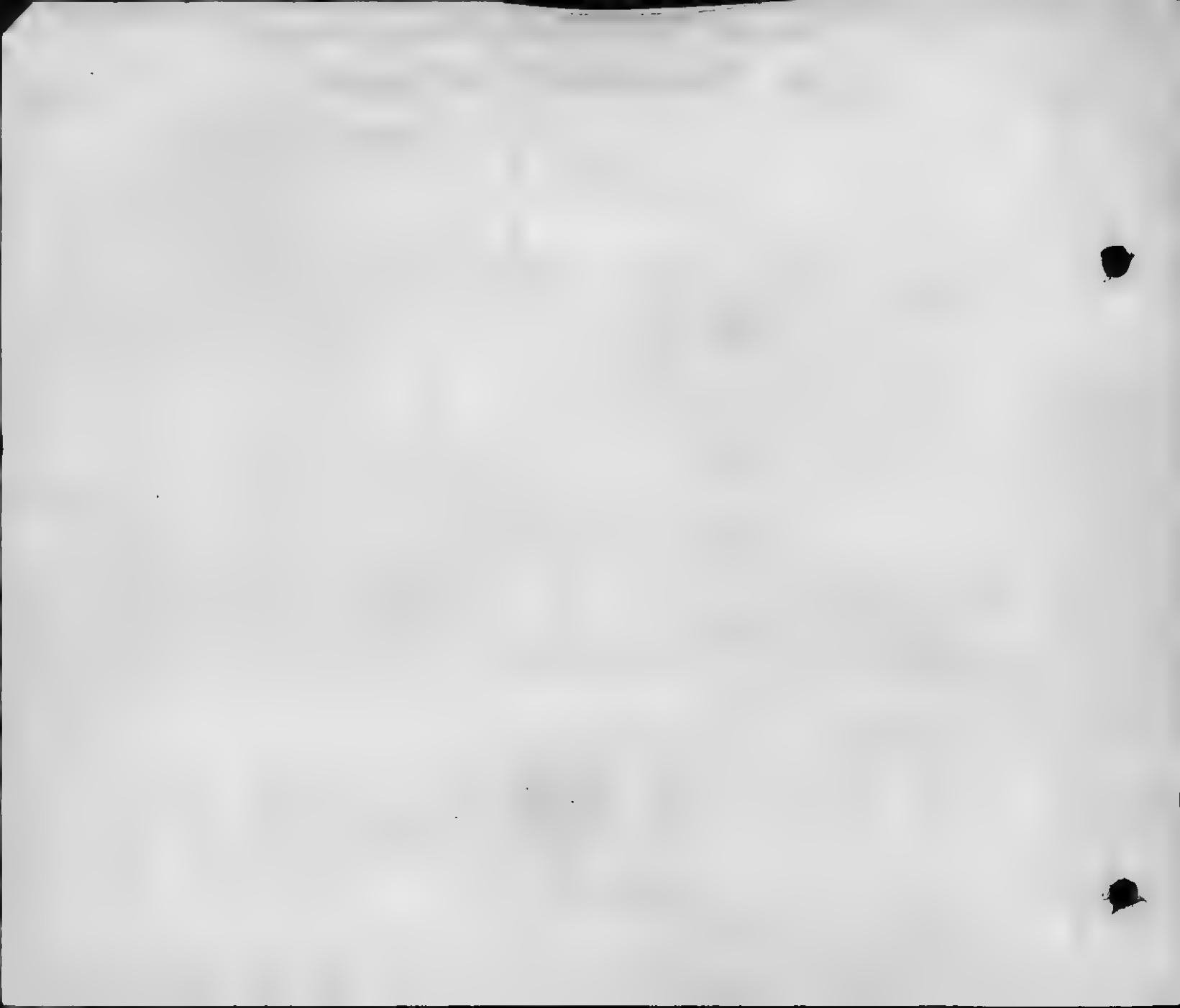
Item 7 Film G297 10/16/61 iwk

11379

CERTIFICATE OF DEATH

Reg. Dist. No. 11365

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED				
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place) YEARS	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	MARYLAND COUNTY NEW WINDSOR RURAL (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS	SAMS CREEK	STREET ADDRESS	SAMS CREEK			
3. NAME OF DECEASED (Type or Print)	(First) EMORY	(Middle)	(Last) ECKER			
4. DATE DEATH	(Month) Oct.	(Day) 5	(Year) 1961			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Deys
M	W	Widower	JAN 4- 1875	86	Yrs.	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?			
FARM	BY DAY FARM	MARYLAND	USA			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME					
FREDERICK ECKER	SARAH FRITZ					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS				
NO	920-10-5919	PEARLIE HOOPER NEW WINDSOR				
II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH approximately		
42-1 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO	(A) <i>acute myocardial infarction</i>	(B) <i>thrombocytopenic purpura-thrombocytopenia</i>	(C)	hours		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST				days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH						
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?				
M.						
22. I hereby certify that I attended the deceased from <u>Oct 29</u> , 1961, to <u>Oct 5</u> , 1961, that I last saw the deceased alive on <u>Oct 3</u> , 1961, and that death occurred at <u>3:07 P.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city, town, state)	DATE SIGNED <u>30 October 1961</u>	
SIGNATURE <u>Dr. E. J. Etteman</u>	M.D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county) (State)			
BURIAL	OCT 8-1961	BETHEL	NEW WINDSOR RURAL MD			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				
DATE OCT 10 '61	S. Etteman	<u>Dr. Hartley Stone New Windsor</u>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11380

CERTIFICATE OF DEATH

11366

TO A HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M

1. PLACE OF DEATH

a. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

MARYLAND

c. LENGTH OF STAY IN 1b

13 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

60 South Market Street

3. NAME OF DECEASED (Type or print)

First
GeorgeMiddle
F.Last
Federline

4. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED b. DATE OF BIRTHWIDOWED DIVORCED

March 2, 1897

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Owner of Diamond Bowling Alley

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Laurel, Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles E. Federline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Fred. Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
(IMMEDIATE CAUSE) (a)

Acute coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

30 min

DUE TO
(b)

Coronary heart disease

6 yrs

Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last.

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 While Not While
at work at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 1st, 1958, to Oct 13, 1961, that (I) (we) last saw the deceased alive on Oct 13, 1961, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE

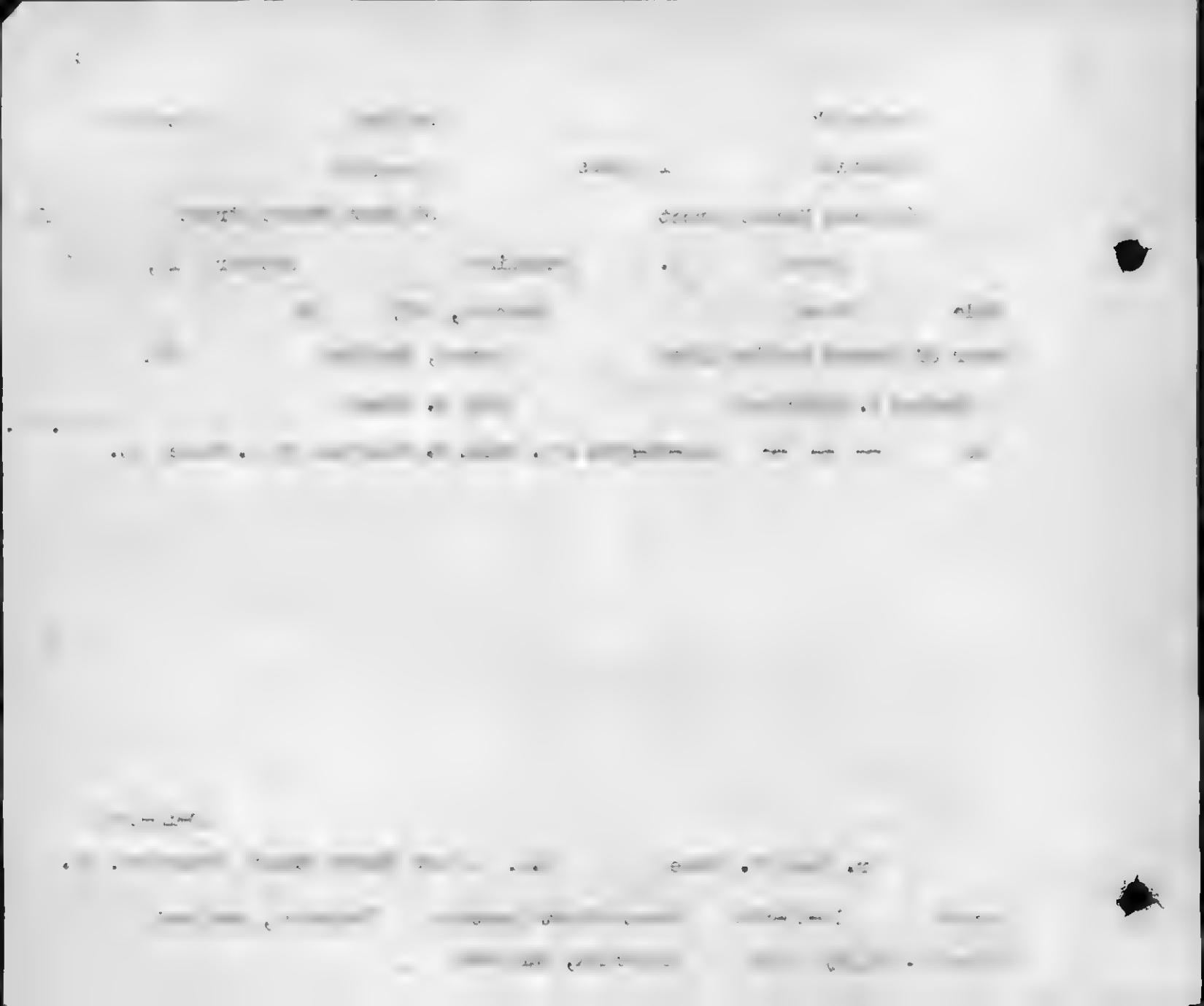
22c. PHYSICIAN'S NAME (Type) Dr. Henry V. Chase M.D. 4 East Church Street Frederick, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 23d. LOCATION (City, town or county) (State)

Burial 10-17-1961 Mount Olivet Cemetery Frederick, Maryland

24. GENERAL DIRECTOR'S SIGNATURE Robert E. Dailey & Son Frederick, Maryland DATE OCT 17 '61

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE



1 MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11381

11367

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Brunswick

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

102 9th Avenue

MARYLAND

c. LENGTH OF STAY IN lb

3. NAME OF
DECEASED
(Type or print)

Edgar

First

Middle

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

b. STATE

Maryland

b. COUNTY

Frederick

e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

35 Brunswick

d. STREET ADDRESS

102 9th Avenue

Last

4. DATE
OF
DEATH

Month

Day

Year

a. IS RESIDENCE
ON A FARM?
YES NO

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

 NEVER MARRIED

8. DATE OF BIRTH

11-2-1900

9. AGE (In years
last birthday)

60

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

Frank Harron

Emma Kidwilder

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO., 17. INFORMANT
(Yes, no, or unknown) (If yes, give rank and dates of service)

No

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH
*Death of Edgar Harron
Hypertension, arteriosclerotic heart
disease* 2-4 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m. Month, Day, Year
p.m. 1920d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 10-10-1961 to 10-10-1961, that (I) (we) last saw the deceased alive on 10-10-1961, and that death occurred 5:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

C. E. PRUITT

22b. DATE
SIGNED
10-12-61

22d. ADDRESS

BRUNSWICK MARYLAND

23a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

23b. DATE THEREOF

10-12-1961

23c. NAME OF CEMETERY OR CREMATORI

Park Heights

23d. LOCATION (City, town or county) (State)

Brunswick, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

B. Hu Field

ADDRESS

Brunswick, Maryland

25a. REC'D. BY REGISTRAR

Oct 17 '61

25b. REGISTRAR'S SIGNATURE

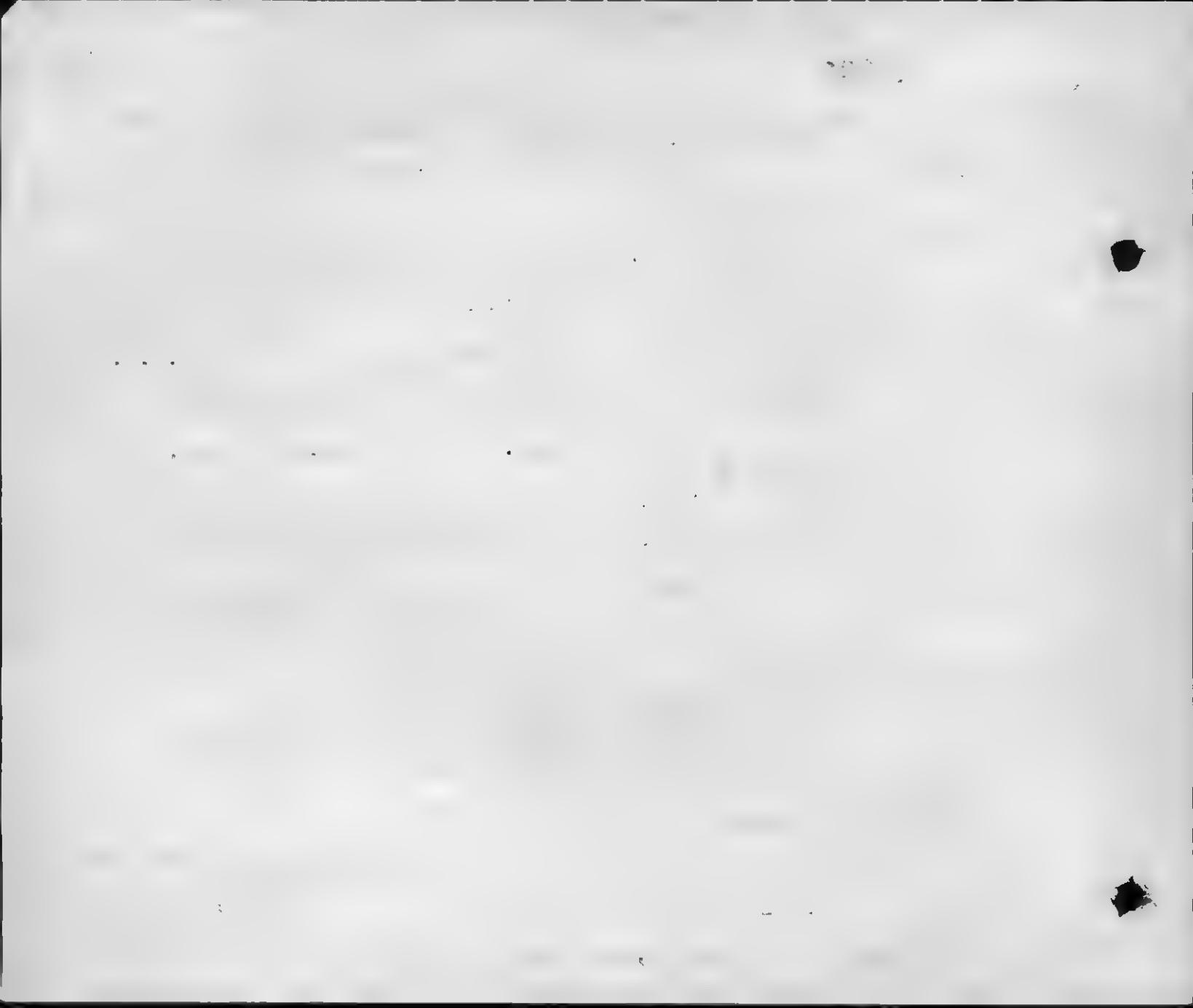
Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
PAGE 4
UNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11382

11368

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural - Burkittsville

c. LENGTH OF STAY IN 1b

17 years

d. NAME OF HOSPITAL OR INSTITUTION (If no in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Frederick

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural - Burkittsville

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

ALBERT

EARL

HARNE

4. SEX

male

6. COLOR OR RACE

white

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

W DOWED

DIVORCED

4. DATE
OF
DEATH

October

1

19

61

9. AGE (In years
last birthday) IF UNDER 1 YEAR

Months Days Hours Mins

IF UNDER 24 HRS.

Hours Mins

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Retired farmer own general farm

Frederick, Co. Md. U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

James O. Harne

Anna Mae Burrier

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

16. SOCIAL SECURITY NO.

[Yes, no, or unknown] [If yes give rank or dates of service]

no

219-36-0094

James R. Harne, Myersville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

163X

DEU TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DEU TO

(c)

Membrane of st. lung
c. Reginal metastasis
Sensitivity

INTERVAL BETWEEN
ONSET AND DEATH

9/20

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH

[IF EITHER, NOTIFY MEDICAL EXAMINER]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

20d. INJURY OCCURRED

While
at work Not While
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

9/20

to 1961

saw the deceased alive on 1961

22a. SIGNATURE

C. E. Pruitt

22b. DATE
SIGNED

22c. PHYSICIAN'S
NAME (Type)

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

Brunswick, Md.

(State)

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORI

burial Oct. 4, 1961

United Brethren

23d. LOCATION (City, town or county)

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Paul F. Bittle, Myersville, Md.

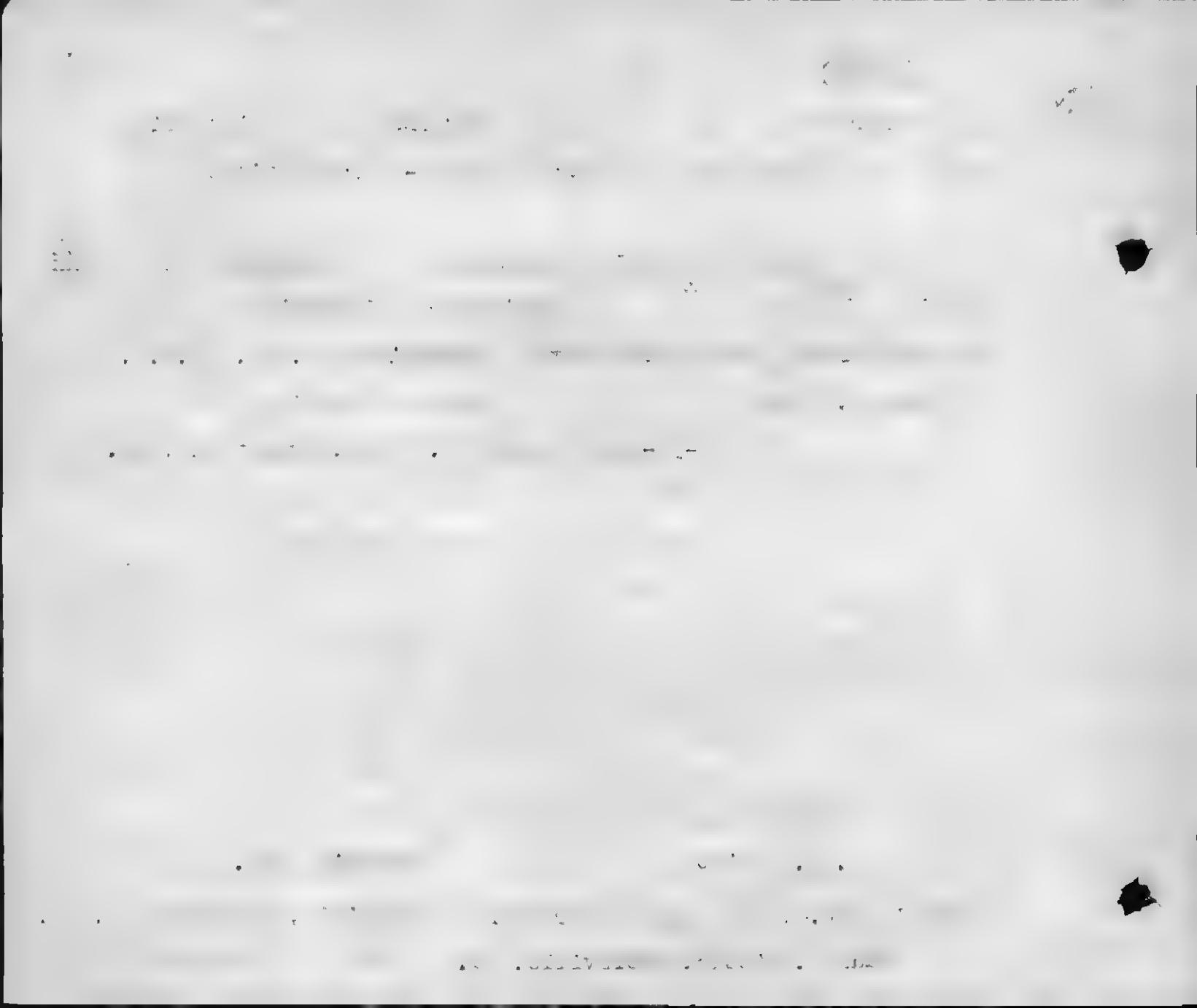
ADDRESS

25a. REC'D BY REGISTRAR

OCT 5 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Tamm



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

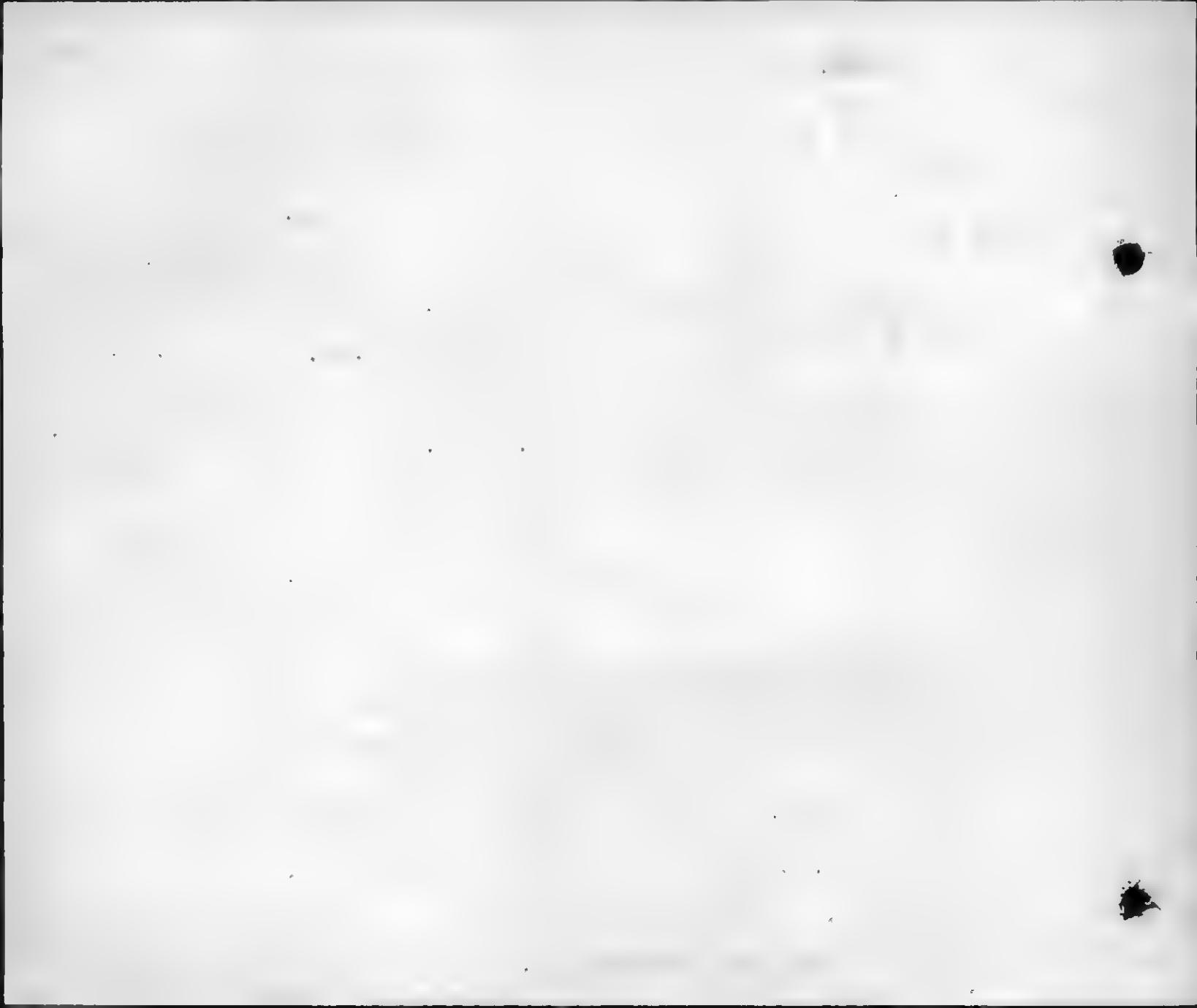
V5 A15 (4)
 ISM 9/58

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11383 CERTIFICATE OF DEATH 11369

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Frederick				a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY Frederick	
Emmitsburg,		Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS	
124 South Seton				124, South Seton Ave.	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Edith		Bell		Havner	October 7, 1961
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	
Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	October 8, 1880	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
80 yrs.		Housewife		Frederick Co. Md.	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John Keilholtz		Missouri Bell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		INFORMANT	
		None		Mrs. John J. Hollinger, Emmitsburg, Md.	
17. MEDICAL CERTIFICATION		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address 124 South Seton Ave. Emmitsburg, Md.	
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH The	
433		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		cerebral embolism	
		(b)		arricular fibrillation 5 years	
		DUE TO (c)		arteriosclerotic C.V. disease Several years	
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)	
20f. (City or town)				(County)	
				(State)	
21. I certify that I attended the deceased from <u>June 1, 1960</u> to <u>Oct 7, 1961</u> , that I last saw the deceased alive on <u>Oct 7, 1961</u> , and that death occurred on <u>Oct 7, 1961</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED <u>Frederick, Md. 10-9-61</u>	
ACTUAL SIGNATURE <u>W.R. Cadle</u>		M.D.			
PHYSICIAN'S NAME (Type) Dr. W. R. Cadle		Emmitsburg, Md.			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 10, 1961		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Tabor Cemetery	
22d. LOCATION (City, town, or county) Rocky Ridge, Frederick Co. Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Wilson</u>		ADDRESS Emmitsburg, Md.		24a. REC'D BY REGISTRAR DATE OCT 10 '61	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>	
C. E. Wilson					



TO HOSPITAL OR ATTEND. PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health until 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11384

CERTIFICATE OF DEATH

11370

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural Thurmont

c. LENGTH OF STAY IN HOSPITAL

Lifetime

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Own Home

3. NAME OF DECEASED
(Type or print)

Ralph Gaver Hessong

First

M

4. SEX

male

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

July 18, 1892

9. AGE (in years
last birthday)

69

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

Own Farm

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John T. Hessong

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or defense service)

Yes

16. SOCIAL SECURITY NO.

215-36-6664

17. INFORMANT

Gladys H. Hessong

Address

Thurmont, Md. RD 1

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Heart disease Atherosclerotic type

Conditions, if any which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Aortic and mitral Stenosis

Angina pectoris

INTERVAL BETWEEN
ONSET AND DEATH

4 years

4 yrs.

4 yrs.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

None

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from **Aug 39-57** to **Oct 26, 1961**, that (I) (we) last
saw the deceased alive on **Oct. 25, 1961**, and that death occurred at **6:27 A.M.** from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

James K. Gray

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

22b. DATE
SIGNED

10-27-61

Thurmont, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

10-28-61

23c. NAME OF CEMETERY OR CREMATORIUM

Blue Ridge Cemetery

23d. LOCATION (City, town or county)

Thurmont, Maryland (State)

24. FUNERAL DIRECTOR'S SIGNATURE

Raymond Conner

ADDRESS

Thurmont, Md.

25a. REC'D BY REGISTRAR

Oct 30 '61

25b. REGISTRAR'S SIGNATURE

Charles L. Thomas

8072 a +

12
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11385

CERTIFICATE OF DEATH

11371

1. PLACE OF DEATH

a. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate lim ls, write RURAL and give nearest town)

Knoxville, Route #1

c. LENGTH OF STAY IN lb

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Knoxville, Maryland, route #1.

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Frederick

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Knoxville, Maryland, route #1.

d. STREET ADDRESS

Knoxville, Maryland, route #1

e. IS RESIDENCE ON A FARM?

YES NO

Year

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

Male

White

WIDOWED

DIVORCED

Hope

October

23

19 61.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE County & State, or foreign country

13. FATHER'S NAME

John Alexander Hope, Sr.

Frederick County

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

214-42-1238 John Alexander Hope, Sr. Knoxville, route #1.

18. CAUSE OF DEATH (Enter only one cause per item (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

200.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. } (b)

DUE TO

(c)

Generalized metastasis,
Lympho Sarcoma

INTERVAL BETWEEN
ONSET AND DEATH

2 mo.

6 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from
saw the deceased alive on

July 1961 to 10/23/1961, that (I) (we) last
death occurred at 7:10 P.M. from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

A. Talbott Brice, M.D.

22b. DATE SIGNED

Oct. 25, 1961

22d. ADDRESS

Jefferson, Maryland.

23a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

23b. DATE THEREOF

10/26/61

23c. NAME OF CEMETERY OR CREMATORIAL

Union Cemetery

23d. LOCATION (City, town or county) (State)

Leesburg, Virginia.

24. FUNERAL DIRECTOR'S SIGNATURE

By *Frank R. Knapp Jr.*
M.R. Etchison & Son, Frederick, Maryland.

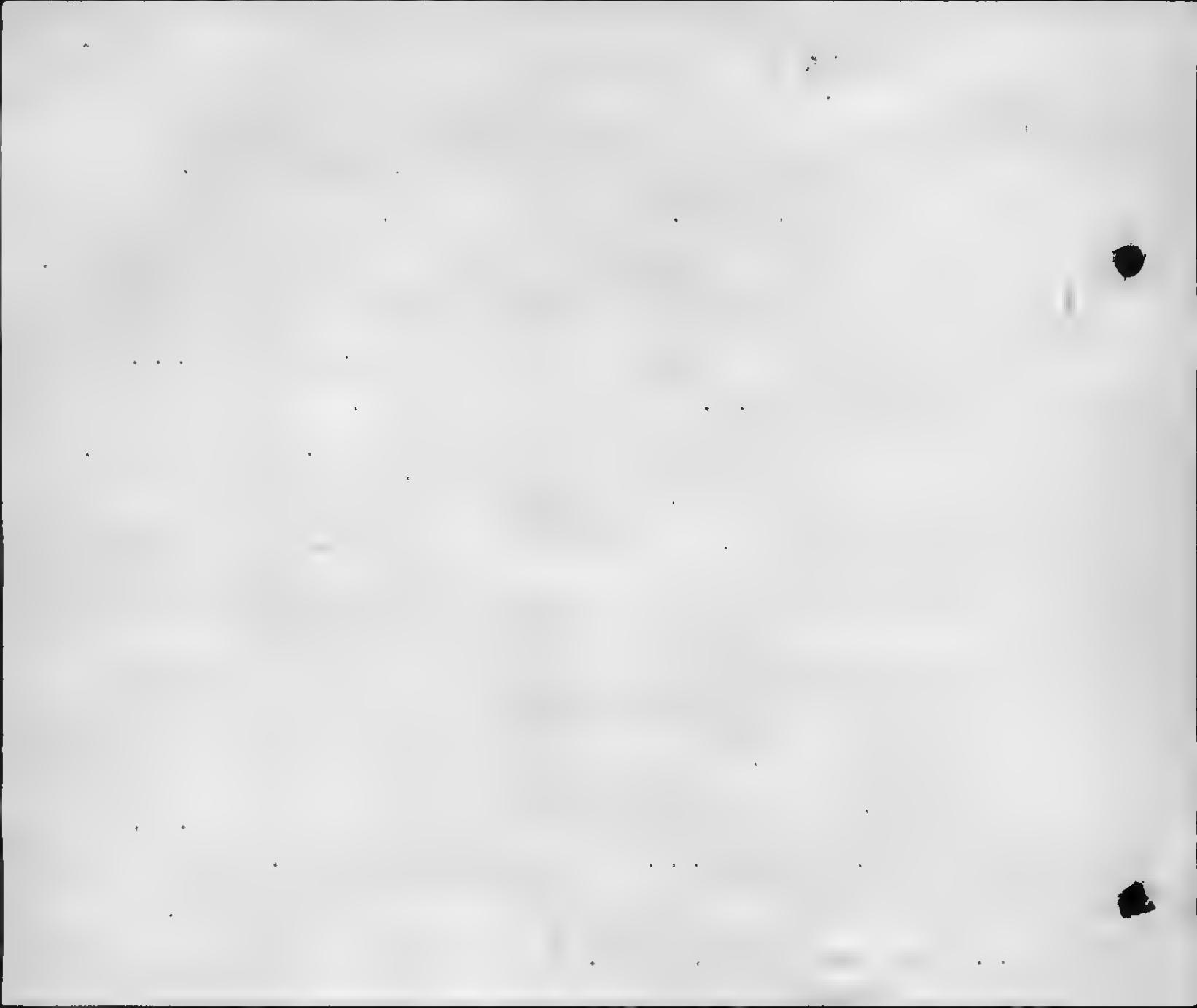
25a. REC'D BY REGISTRAR

DATE

OCT 26 1961

25b. REGISTRAR'S SIGNATURE

Frank R. Knapp Jr.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

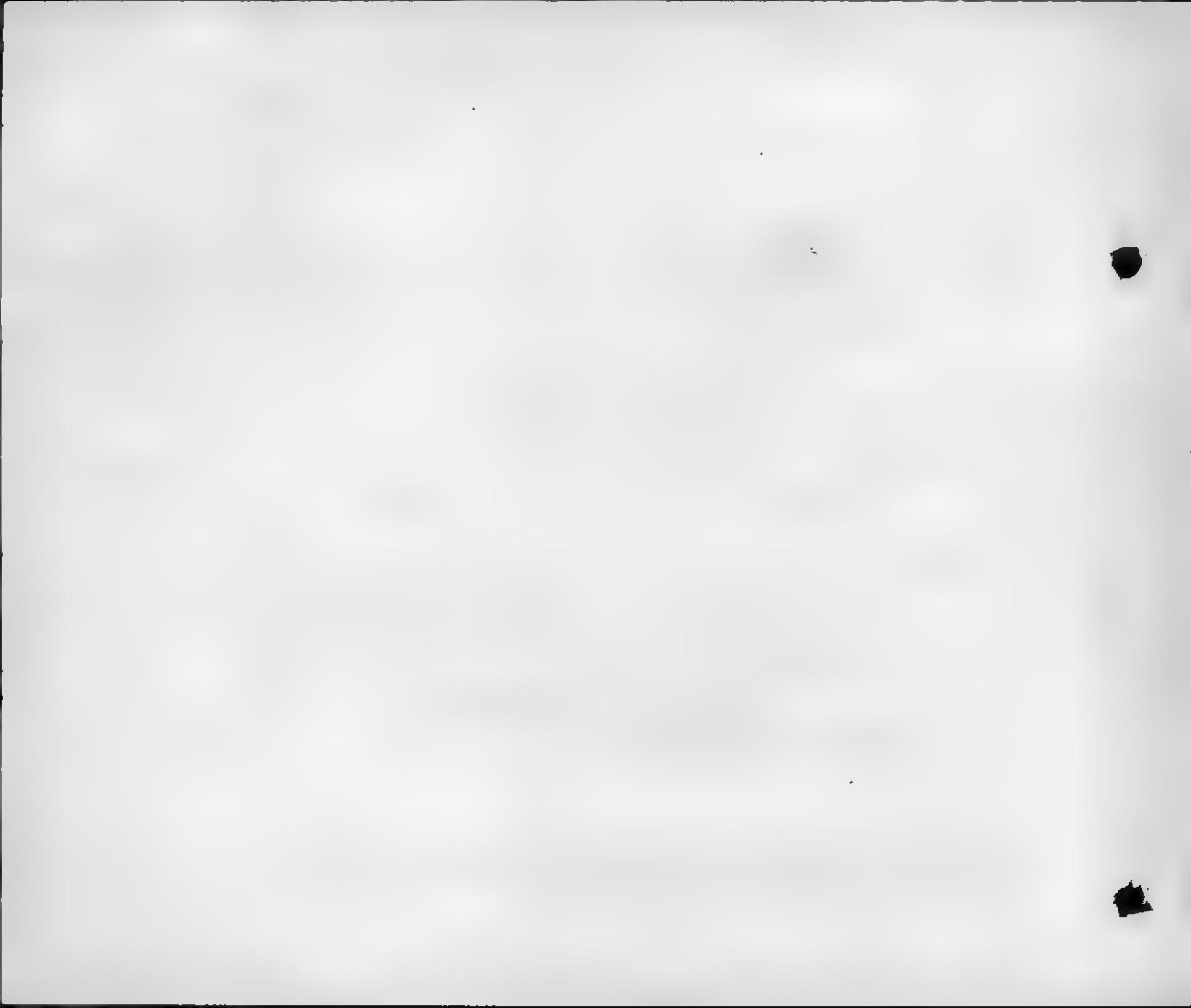
11385

CERTIFICATE OF DEATH

Reg. Dist. No. 11372

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 To be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND		b. COUNTY FREDERICK				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE		c. LENGTH OF STAY IN 1b 2 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODSBORO		d. STREET ADDRESS CENTERVILLE				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RURAL				d. STREET ADDRESS CENTERVILLE		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ANNA		First LEE	Middle HOUGH	Last HOUGH	4. DATE OF DEATH OCT. 5	Month OCT.	Day 5	Year 1961		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> JAN 11- 1893	9. AGE (In years lost, birthday) 68 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 68		Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME JACOB ALLISON		14. MOTHER'S MAIDEN NAME CATHERINE ALLISON								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT SAMUEL W HOUGH		Address WOODSBORO MD				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO cardiac degeneration collapse										INTERVAL BETWEEN ONSET AND DEATH 2 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from March 1, 1961 to October 5, 1961 , that I last saw the deceased alive on Oct. 4, 1961 , and that death occurred at 8:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Union Bridge, Maryland										DATE SIGNED 10-5-61
ACTUAL SIGNATURE J. N. Legg		M.D.								
PHYSICIAN'S NAME (Type) T. H. Legg, M.D.		Union Bridge, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT 8-1961		22c. NAME OF CEMETERY OR CREMATORIUM ROCKY HILL		22d. LOCATION (City, town, or county) FREDERICK CO MD		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE W. Hartley & Sons		ADDRESS Union Bridge, Maryland		24a. REC'D BY REGISTRAR DATE OCT 10 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Krause				



FOR STATE
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.
To execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to a funeral director. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11387

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11373

1. PLACE OF DEATH

a. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Brunswick

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

MARYLAND

c. LENGTH OF STAY IN lb

Life

3. NAME OF
DECEASED
(Type or print)

First

Ernest

Middle

McARTHER

Last

Hoyser

4. DATE
OF
DEATH

October 22

Month

Day

19 61

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED

WIDOWED

8. DATE OF BIRTH

Divorced

July 19, 1903

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

9. AGE (In years
last birthday)

58 yrs.

IF UNDER 1 YEAR
Months Days Hours Min.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George W. Houser

14. MOTHER'S MAIDEN NAME

Nora Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

No

16. SOCIAL SECURITY NO.

236-03-1547

17. INFORMANT

Charles Harrington, Brunswick, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

1/1X
DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Acute Congestive Heart Failure

INTERVAL BETWEEN
ONSET AND DEATH
1 hr.

Ch. Rheumatic H. D. (Aortic Stenosis) Yes.

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour e.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

19

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

October 23, 1961

DATE SIGNED

Address (Street, city, town, or county)

22e. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

10-24-1961

22c. NAME OF CEMETERY OR CREMATORI

MOUNTAIN VIEW

22d. LOCATION (City, town, or country)

(State)

SHARPSBURG, MARYLAND

23. FUNERAL DIRECTOR

ADDRESS

John E. Brunswick, MARYLAND

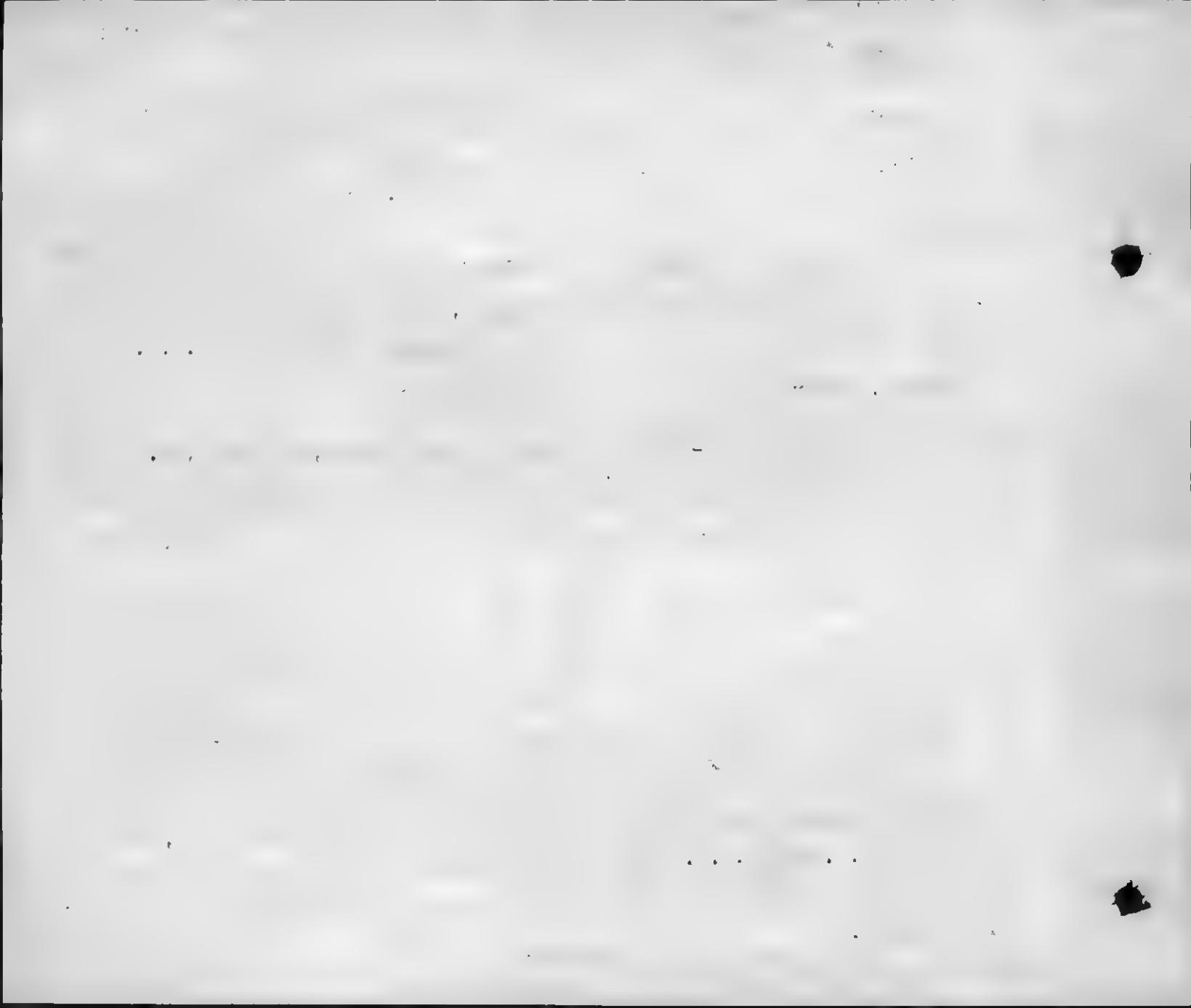
24e. REC'D BY REGISTRAR

OCT 26 '61

DATE

24b. REGISTRAR'S SIGNATURE

Charles S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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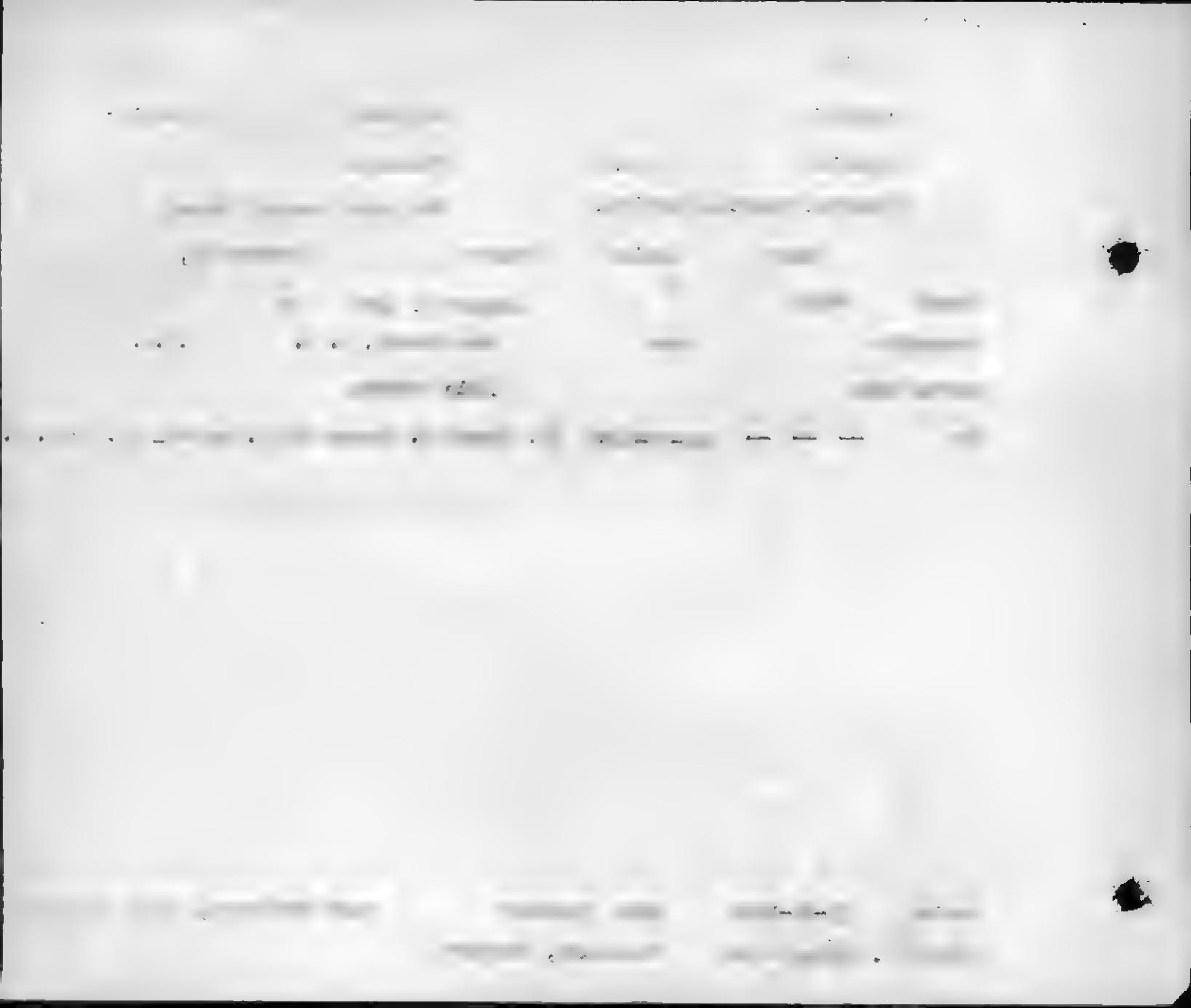
MARY Louise Houser

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11374

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 224 South Carroll Street				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Mary		First	Middle	Last	4. DATE OF DEATH October 10,	Month	Day	Year 19 61		
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH January 2, 1926	9. AGE (in years last birthday) 35	IF UNDER 1 YEAR yrs. 0	IF UNDER 24 HRS Months 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ashe County, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Martin Ward		14. MOTHER'S MAIDEN NAME Alsie Osborne								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No		16. SOCIAL SECURITY NO 408-38-0403		17. INFORMANT Mr. Ernest E. Houser 224 S. Carroll St. Fred. Md.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH 8 weeks
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis with primary presumably in the biliary system</i>										
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 8-18 , 1961, to 10-10 , 1961, that (I) (we) last saw the deceased alive on 10-10 , 1961, and that death occurred at M , from the causes and on the date stated above.										
22a. SIGNATURE <i>Rex R. Martin</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) Rex R. Martin		22d. ADDRESS Frederick, Md								
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 10-11-1961		23c. NAME OF CEMETERY OR CREMATORIAL Ward Cemetery		23d. LOCATION (City, town, or county) West Jefferson, North Carolina		(State)		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Dailey & Son</i>		ADDRESS Frederick, Maryland		25a. REC'D BY REGISTRAR Oct 16 '61		25b. REGISTRAR'S SIGNATURE <i>S. Evans</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

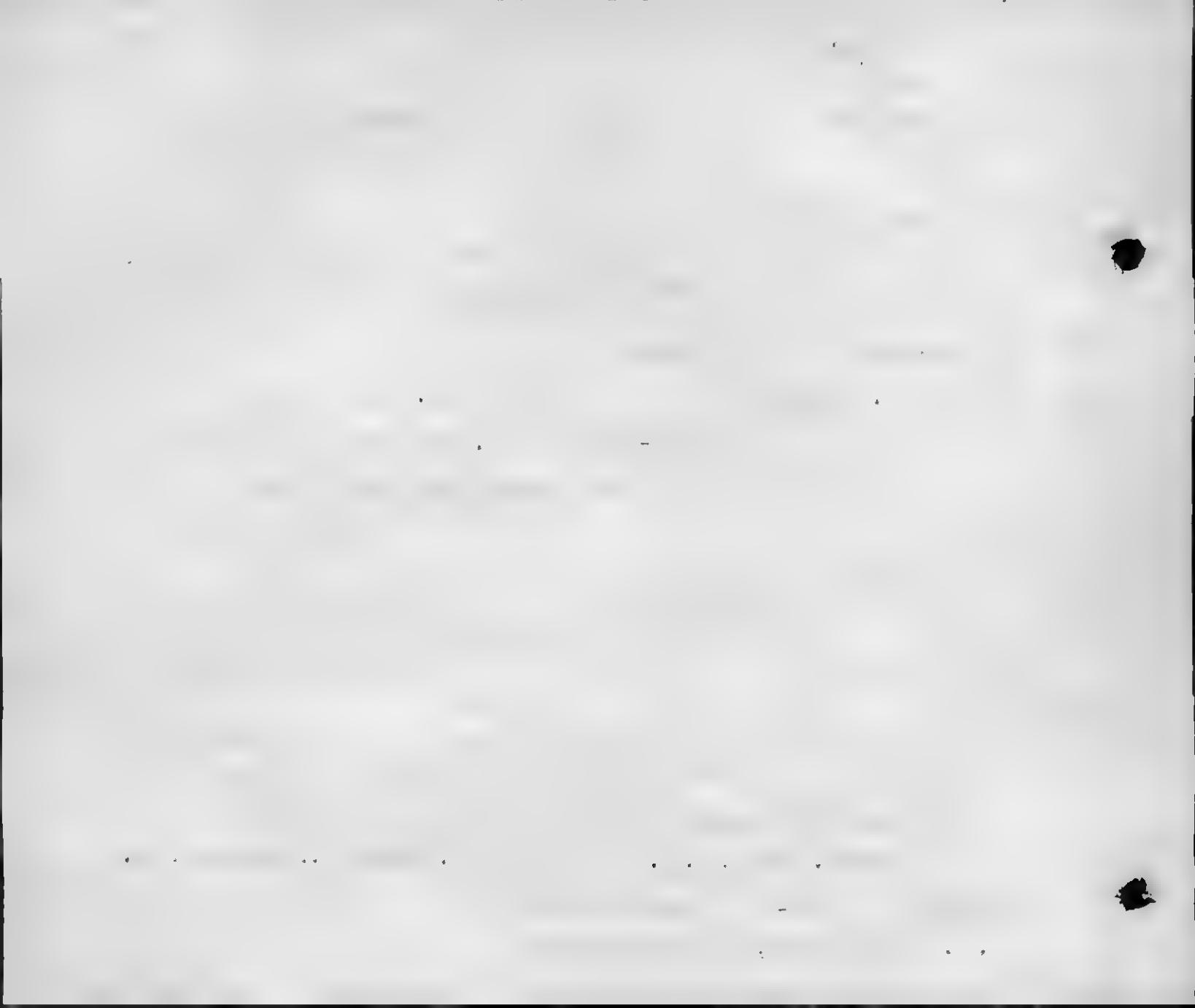
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11389 11375

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Frederick		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b 40 Years		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 321 Queen Street	d. STREET ADDRESS 321 Queen Street		
3. NAME OF DECEASED (Type or print) EVELYN	4. DATE OF DEATH Month October Day 13 , Year 1961		
5. SEX Female	5. COLOR OR RACE White	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH 23 April 1921
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (County & State, or born in country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Clayton C. Lenhart	14. MOTHER'S MAIDEN NAME Effie E. White	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. 215-14-1570	17. INFORMANT Elmer A. Hull (Same as item #1)	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO Fatty metamorphosis of the liver with focal necrosis Day to weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a)			
20a. TIME OF INJURY Hour a.m. 19 p.m.	20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20c. (City or town)	(County) Frederick (State) Md.
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	21. I certify that (I) (this hospital) attended the deceased from July 1961 to Oct. 13 , 1961, that (I) (we) last saw the deceased alive on Oct. 10 , 1961, and that death occurred at 8P.M. from the causes and on the date stated above.	22b. DATE SIGNED 16 Oct 1961	
22a. SIGNATURE <i>Rex R. Martin</i>	22c. PHYSICIAN'S NAME (Type) Rex R. Martin, M. D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 220 N. Market St., Frederick, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 10-17-61	23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	23d. LOCATION (City, town or county) Frederick, Maryland (State) Md.
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland	ADDRESS M. R. Etchison & Son, Frederick, Maryland	25a. REC'D BY REGISTRAR OCT 19 1961	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Haas</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11390

11376

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Frederick Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First MIDDLE

Last

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED DIVORCED

March 13, 1872

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

13. FATHER'S NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

X DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last. } (b)

DUE TO

(c)

16. SOCIAL SECURITY NO 17. INFORMANT

None

Hospital Records

Address

INTERVAL BETWEEN
ONSET AND DEATH

3 days

1 year

MEDICAL CERTIFICATION

19. WAS AUTOPSY
PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 White Not White
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 4, 1957, to Oct. 12, 1961, that (I) (we) last
saw the deceased alive on Oct. 12, 1961, and that death occurred at 11:30 P.M. on the causes and on the date stated above.

22e. SIGNATURE

Thomas E. Stone

M.D.

ATTENDING
PHYSMED.
DIRECTORSTAFF
PHYS.

Oct. 16, 1961

22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

Thomas E. Stone MD

4 West 3rd Street, Frederick, Maryland

23e. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

Burial

Oct. 16, 1961 Reformed Cemetery

Middletown

Maryland

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

DACT 18 '61

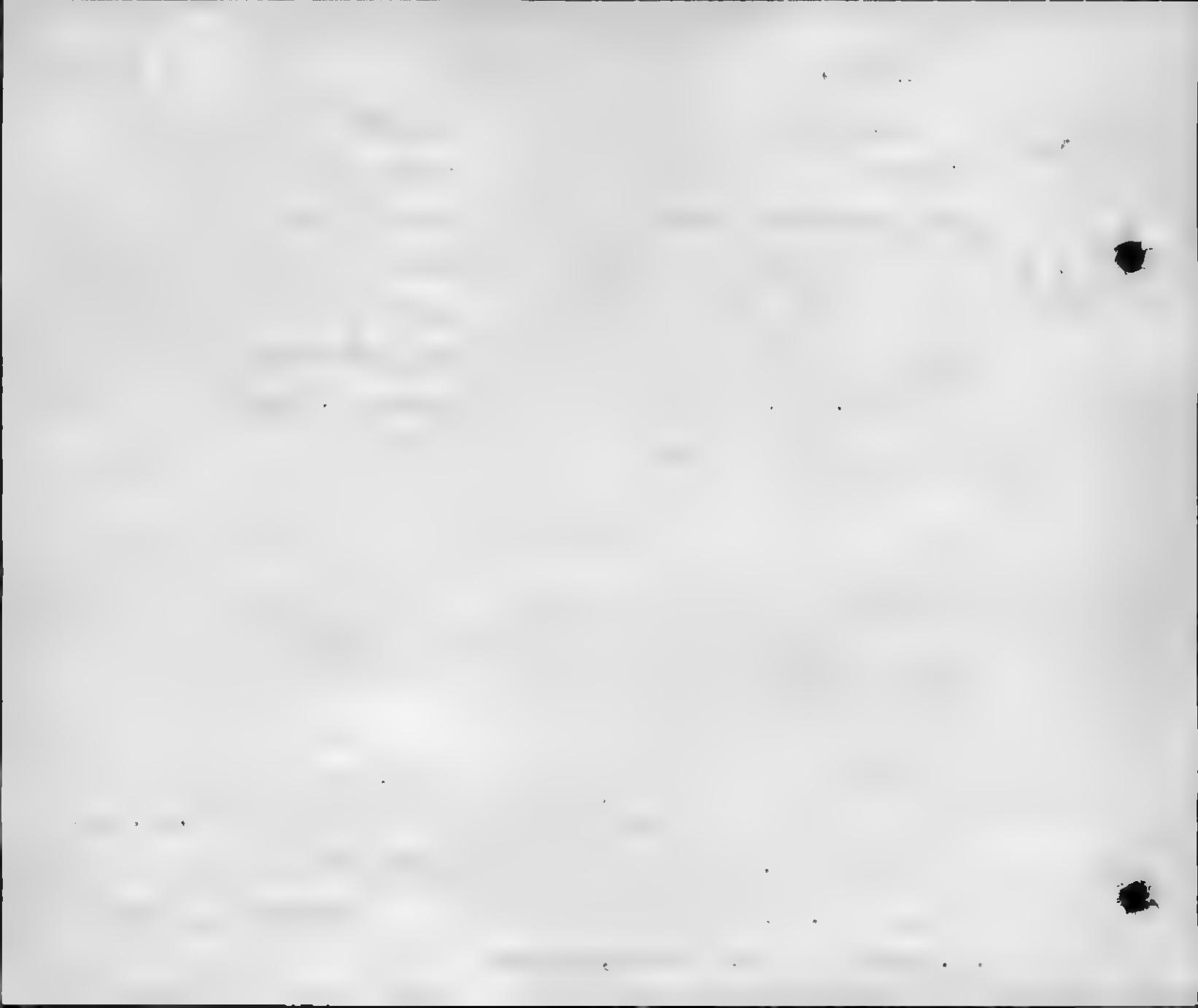
25b. REGISTRAR'S SIGNATURE

Charles S. Etchison

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the physician or attending physician has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14
M
I
15A 15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11397

CERTIFICATE OF DEATH

11377

1. PLACE OF DEATH

a. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

MARYLAND

4 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Frederick Memorial Hospital

3. NAME OF DECEASED (Type or print)

First

Middle

Robert

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED WIDOWED

8. DATE OF BIRTH

DIVORCED

James Sr.

Last

Month

Day

276 W. 5th St. Frederick, Maryland

4. DATE OF DEATH

October

Month

21

Day

1961

Year

e. IS RESIDENCE ON A FARM?

YES NO

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Warehouse

10b. KIND OF BUSINESS OR INDUSTRY

Fort Detrick

11. BIRTHPLACE (County & State, or foreign country)

Frederick, Maryland.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry C. James.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

Yes

W.W. #1

16. SOCIAL SECURITY NO.

17. INFORMANT

217-10-9148 Mrs. Maude Hood James (same as item #2)

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

CEREBRAL THROMBOSIS

DUE TO

Conditions, if any, which give rise to immediate cause (b)

HYPERTENSIVE

DUE TO

ARTERIOSCLEROTIC

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

PAROVOASCULAR Disease

INTERVAL BETWEEN ONSET AND DEATH

48 hours

8+ years

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

6/11 1960 to 10/21 1961

saw the deceased alive on 10/21 1961, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

22. SIGNATURE

Richard C. Reynolds,

M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

22b. DATE SIGNED
Oct. 23, 1961

22c. PHYSICIAN'S NAME (Type)

Richard C. Reynolds, M.D.

9 East Church Street, Frederick, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

Burial

10/24/61

Mount Olivet Cemetery

Frederick, Maryland.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

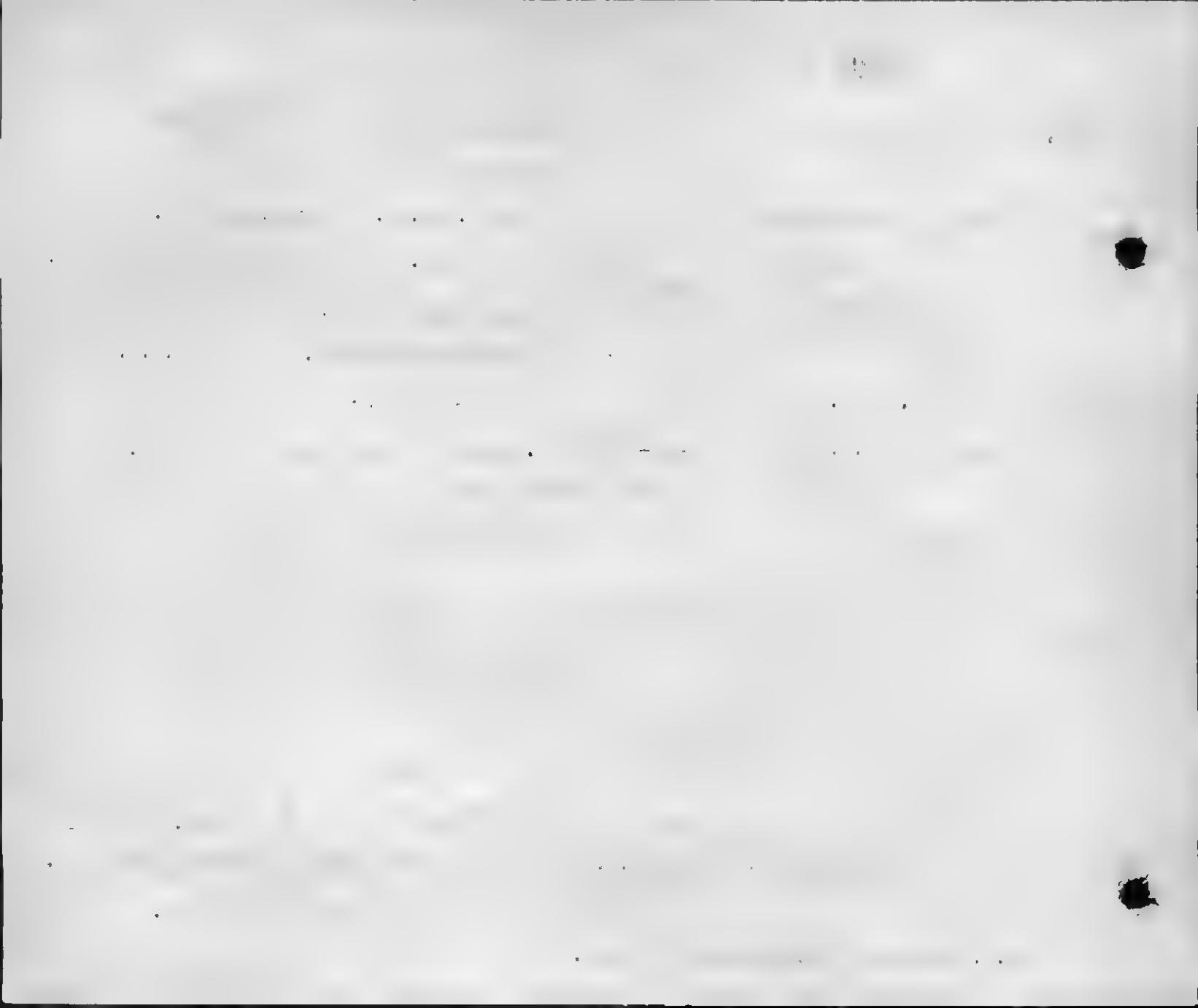
25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

M.R. Etchison & Son, Frederick, Maryland.

OCT 24 '61

Charles S. Etchison



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11392

CERTIFICATE OF DEATH

11378

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH
a. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Frederick County Chronic Hospital

3. NAME OF
DECEASED
(Type or print)

First Middle

CLARA

JEANETTE

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Female

White

WIDOWED DIVORCED

December 15, 1870

9. AGE (in years) IF UNDER 1 YEAR, IF UNDER 24 HRS.

Last birthday Months Days Hours Min.

10. LSUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. PLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY

13. FATHER'S NAME

At Home

14. MOTHER'S MAIDEN NAME

USA

John Bussard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Elizabeth Himes

Address

No

None

Mr. Ralph O. Koontz Jefferson, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Carcinoma right eye

INTERVAL BETWEEN
ONSET AND DEATH

84 months

X DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last, (b)

DUE TO

cause last, (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Chronic cardiac vascular disease

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

Hour
e.m.

p.m.

Month, Day, Year

19

While
at work Not While
at work

(City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Mar 1961 to Oct 9, 1961, that (I) (we) last saw the deceased alive on Oct 9, 1961, and that death occurred at 11:15 AM from the causes and on the date stated above.

22a. SIGNATURE
H. F. Kline22b. DATE
SIGNED
October 16, 196122c. PHYSICIAN'S
NAME (Type)
H. F. Kline MDATTENDING
PHYS. MED
DIRECTOR STAFF
PHYS.

22d. ADDRESS

7 North Market Street, Frederick, Md.

23a. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)
Burial Oct. 16, 1961 St. Paul's Lutheran Cemetery Jefferson Maryland

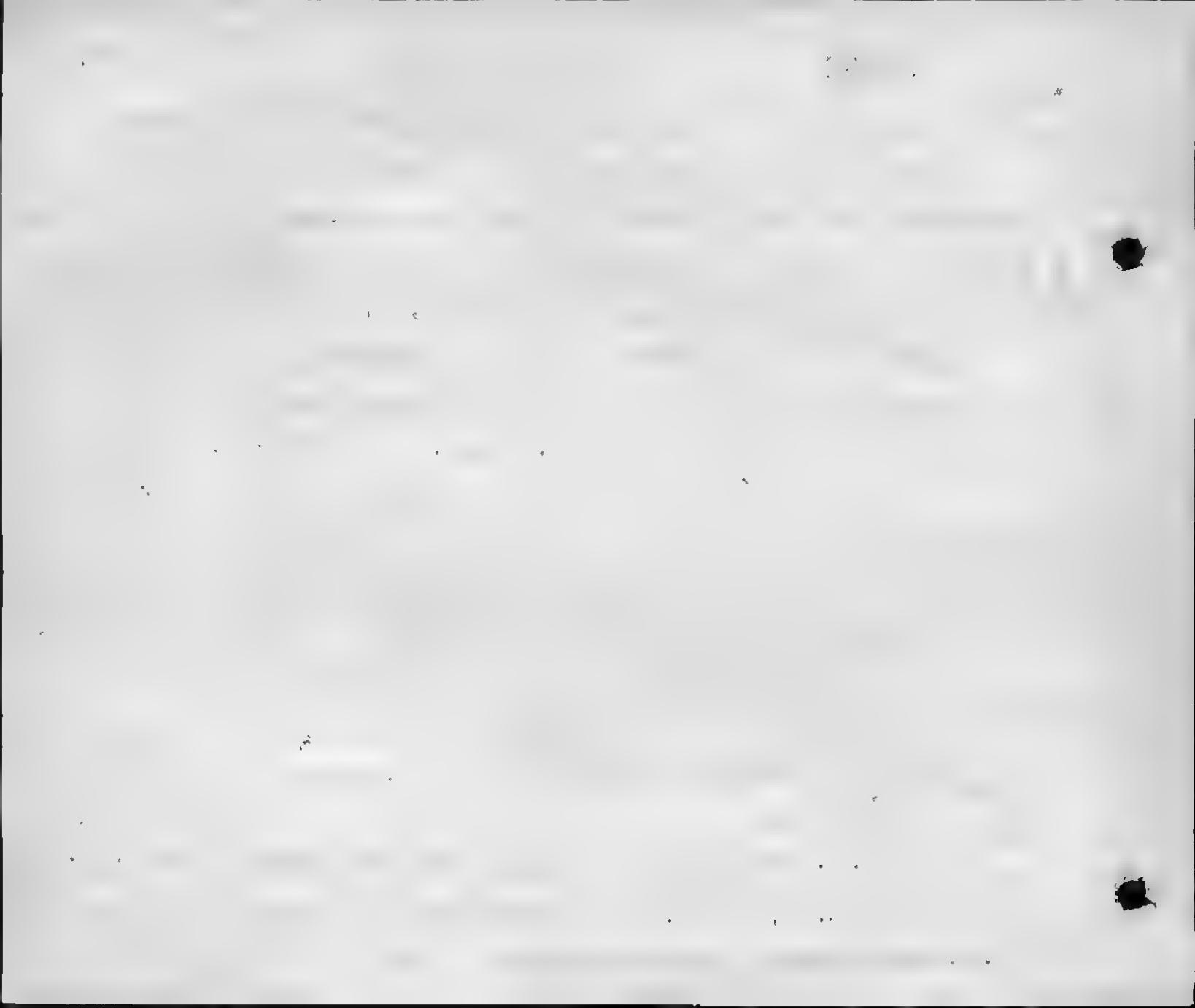
23d. LOCATION (City, town or county) (State)

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

24 FUNERAL DIRECTOR'S SIGNATURE
M. R. Etchison and Son, Frederick, Maryland

OCT 18 '61

Arthur S. Kline



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11393

11379

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

FREDERICK

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL Frederick

c. LENGTH OF STAY IN lb

Lifetime

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Frederick Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

EMERY

BURHAM

LEASE

5. SEX

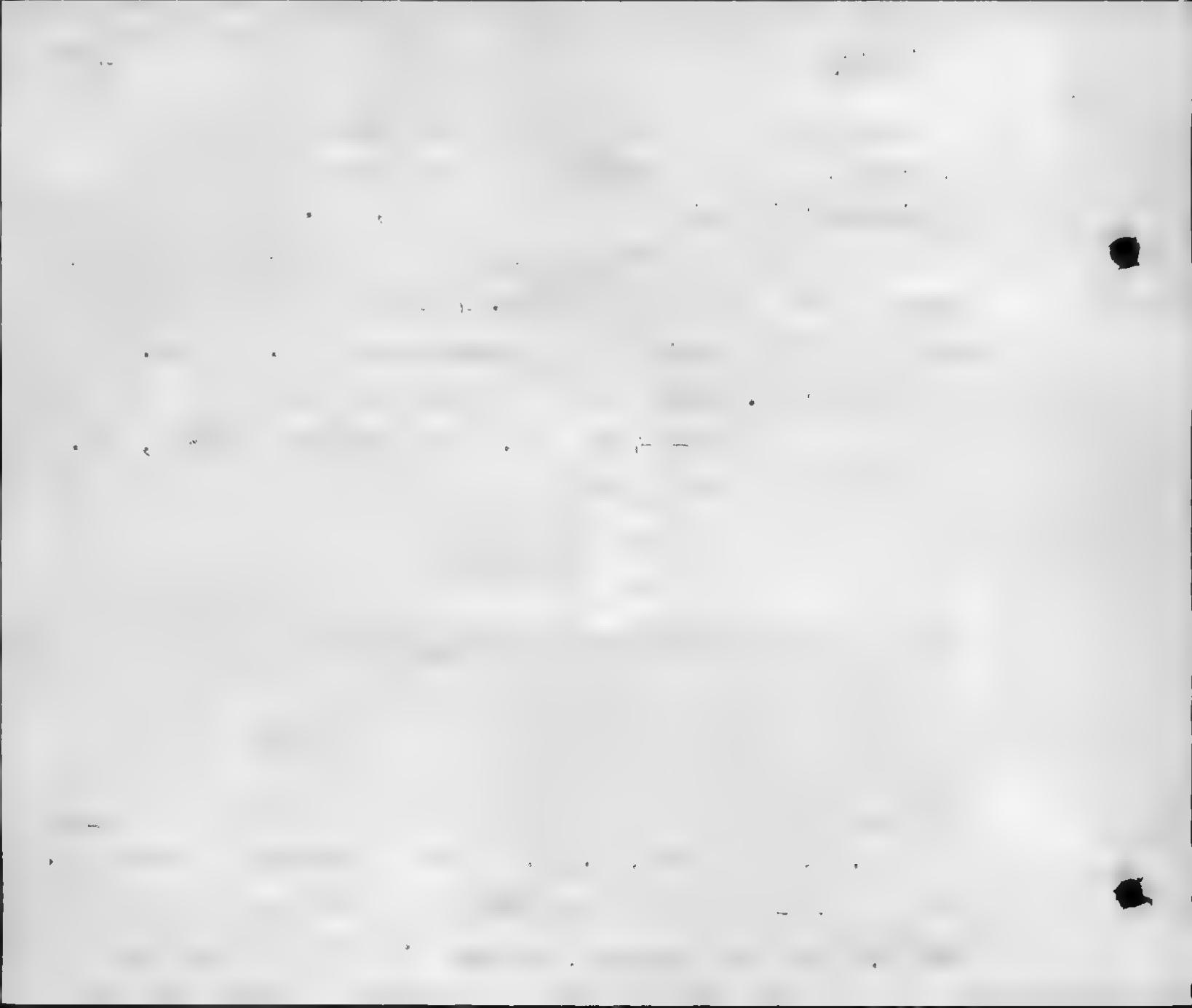
Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED



1
FOR STATE
HEALTH DEPT.

14 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11394

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11380

1. PLACE OF DEATH

a. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

MARYLAND

3 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Frederick Memorial Hospital

e. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Earl

Wilson x ~~xx~~ Lyles

5. SEX

6. COLOR OR RACE

Male

Colored

10a. JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Chauffer delivery truck

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

April 14, 1905

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

Ernest Lyles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

210-14-1786 Hospital records

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cardiac Arrest

INTERVAL BETWEEN
ONSET AND DEATH

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Acute Pulmonary Edema

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

This occurred during an operation for hernia, giving cardiac message

20a. EXTERNAL CAUSE WAS

PRIMARY or CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

White Not White

at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

B.O.Thomas

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

October 13, 1961

NAME (Type)

B. O. Thomas, M.D.

Address (Street, city, town, or county)

22d. LOCATION (City, town, or country)

(State)

22e. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

10-16-61

22c. NAME OF CEMETERY OR CREMATORIUM

Eberneez

22d. LOCATION (City, town, or country)

Frederick Co., Maryland

(State)

23. FUNERAL DIRECTOR

C.E.Hicks III

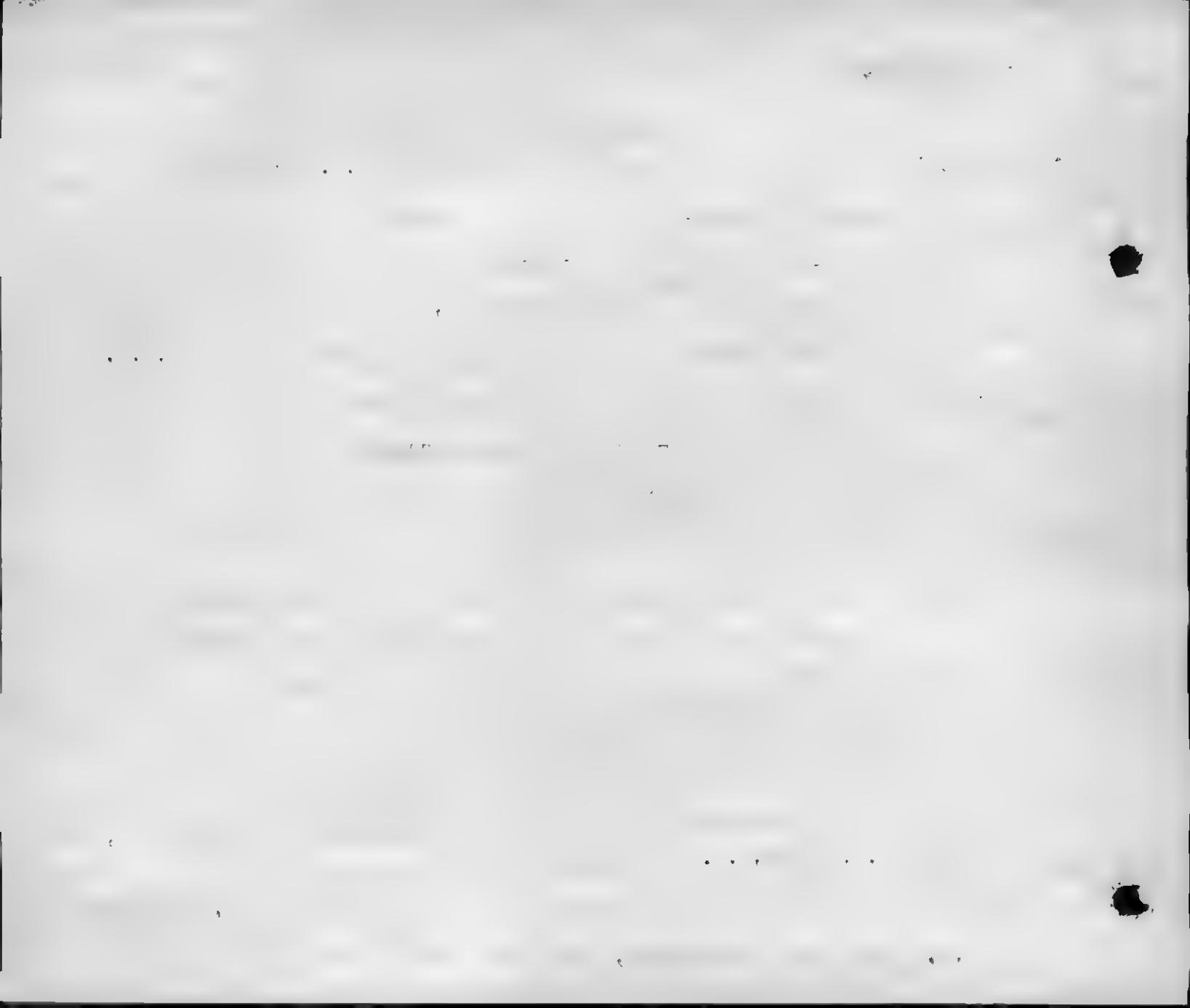
Frederick, Maryland

24e. REC'D BY REGISTRAR

DATE OCT 17 '61

24b. REGISTRAR'S SIGNATURE

Clinton S. Thomas



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

M

11395

CERTIFICATE OF DEATH

11381

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Broad Run (Burkittsville) life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

Franklin

First

Middle

Lost
McDade

5. SEX

Male

6. COLOR OR RACE

White

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

General Utility

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

5-30-1890

13. FATHER'S NAME

Thomas McDade

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOC AL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes, give rank and dates of service)

No

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Acute Congestive Heart disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

During Acute Asthmatic attack.

INTERVAL BETWEEN
ONSET AND DEATH
1 hr

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 1958 to Oct. 9, 1961, that (I) (we) last
saw the deceased alive on Oct. 9, 1961, and that death occurred at 940 P.M. from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

J. Elmer Harp

M.D. ATTENDING
PHYS.
22d. ADDRESSMED.
DIRECTOR
STAFF
PHYS. 22b. DATE
SIGNED
Oct 10 1961

Middletown, Maryland

23a. BURIAL, CREMATION
REMOVAL (Specify)
Burial 10-12-61

23b. DATE THEREOF

Burkittsville

23d. LOCATION (City, town or county)

(State)

Burkittsville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

J. Elmer Harp

ADDRESS

Brunswick, Maryland

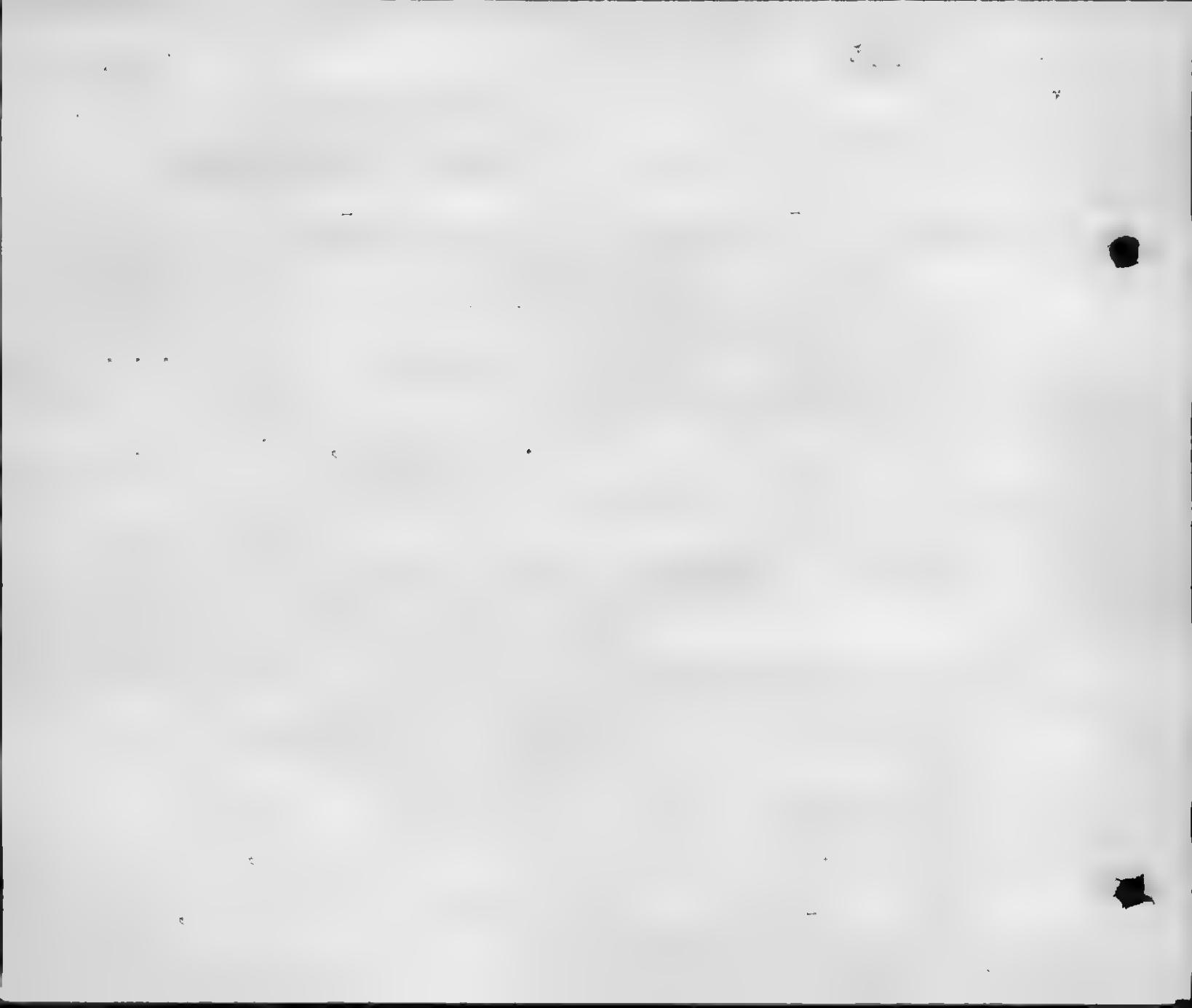
25e. REC'D BY REGISTRAR

OCT 17 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and countersigned by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11396

CERTIFICATE OF DEATH

11382

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH

a. COUNTY
Frederickb. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Sunnyside (rural)c. LENGTH OF STAY IN 16
54 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Rt 4 Frederick, Md

MARYLAND

3. NAME OF
DECEASED
(Type or print)

4. SEX

5. COLOR OR RACE

6. MARRIED
female10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cannery worker

7. NEVER MARRIED

WIDOWED DIVORCED

10b. KIND OF BUSINESS OR INDUSTRY

Cannery

11. BIRTHPLACE (County & State, or foreign country)

Carroll Co., Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Boweary

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give rank or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

220-01-5203 John McKinney

Address

Rt 4 Sunnyside, Fred.

INTERVAL BETWEEN
ONSET AND DEATH

5 mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

120.1

Conditions, injury, which

gave rise to immediate cause

(b), stating the underlying

cause last

} DUE TO

} DUE TO

} DUE TO

19. WAS AUTOPSY
PERFORMED?YES NO 19. WAS AUTOPSY
PERFORMED?YES NO

20c. TIME OF INJURY

Month, Day, Year

Hour e.m.

p.m.

19

20d. INJURY OCCURRED

While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on

10/16/61

1961, and that death occurred at

M, from the causes and on the date stated above.

22a. SIGNATURE

G. E. Brice

22c. PHYSICIAN'S
NAME (Type)

A. T. Brice

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

10-18-61

23b. DATE THEREOF

Sunnyside

ADDRESS

Mrs C. E. Hicks, 111 Frederick, Md

24. FUNERAL DIRECTOR'S SIGNATURE

Arthur S. Kline

25e. REC'D BY REGISTRAR

OCT 20 '61

DATE

25b. REGISTRAR'S SIGNATURE

Arthur S. Kline

26. (State)

11382

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11397

CERTIFICATE OF DEATH

11383

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH

a. COUNTY Frederick

b. CITY OR TOWN (if outside corporate 1 mts, write RURAL and give nearest town) Frederick

c. LENGTH OF STAY IN 1b 88 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Monocacy Hall Nursing Home

3. NAME OF DECEASED (Type or print)

First Middle

Zourie Schroeder

5. SEX

Female White

6. COLOR OR RACE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

Lesl Mobley

4. DATE OF DEATH

1873

Month October

13, 19 61

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker

10b. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (County & State, or foreign country)

Frederick, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George A. Schroeder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Mary Alice Markey 201 Grove Blvd. Fred. Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.

(b)

DUE TO

(c)

Generalized carcinomatosis
Carcinoma, cecumINTERVAL BETWEEN
ONSET AND DEATH
3 months
6 months

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from March 1, 1961, to Oct 13, 1961, that (I) (we) last saw the deceased alive on Oct 12, 1961, and that death occurred at M, from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Dr. B. O. Thomas, Jr.

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

22b. DATE SIGNED
10-13-196123e. BURIAL, CREMATION, REMOVAL (Specify)
Burial 10-16-1961

23c. NAME OF CEMETERY OR CREMATORIAL

Frederick Memorial Park

23d. LOCATION (City, town or county)

Frederick, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE
Robert E. Dailey & Son

ADDRESS

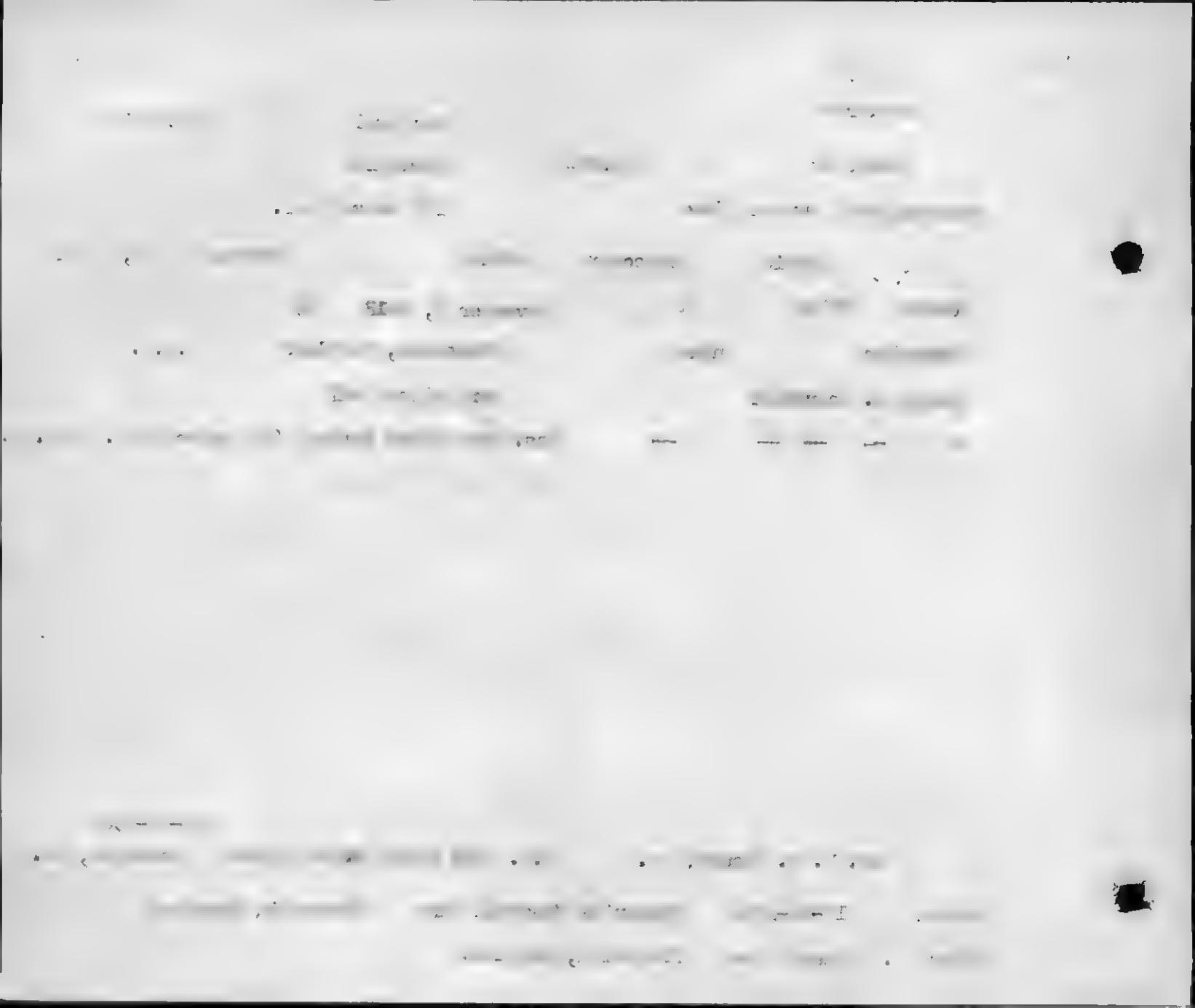
Frederick, Maryland

25e. REC'D BY REGISTRAR

DATE OCT 17 '61

25b. REGISTRAR'S SIGNATURE

Julius S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

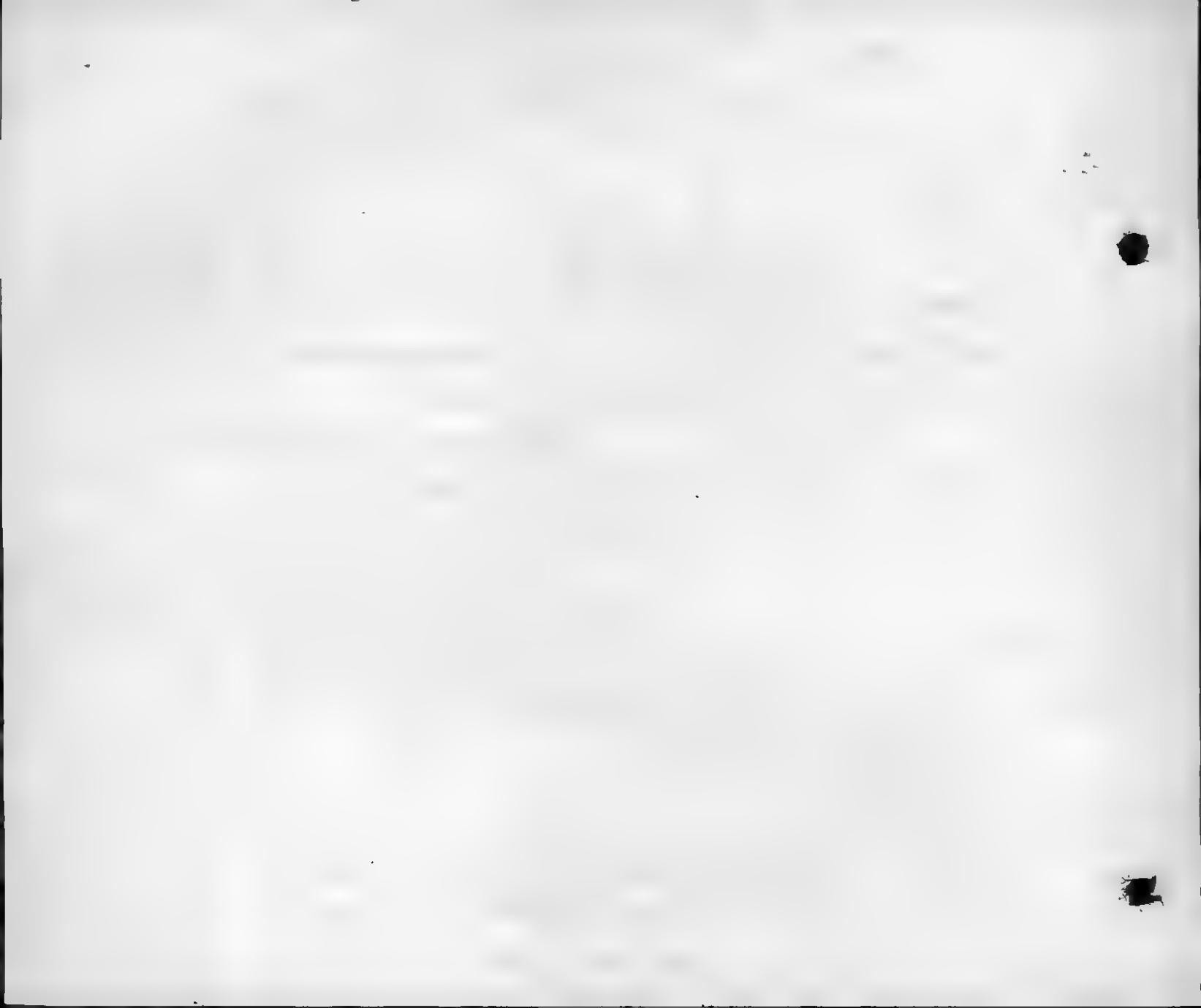
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11384

11398		Item 14 Film G298		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)	
1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick City Hosp.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster	
3. NAME DECEASED (Type or print) DANIEL M. NORRIS		4. DATE OF DEATH OCTOBER 21 1961		d. STREET ADDRESS 06 X-2	
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11-8-1883		9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months 7 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME William Norris		14. MOTHER'S MAIDEN NAME unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Chas. Stowe 4005 Deepwood Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 445		CEREBRAL THROMBOSIS 12 hours			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		HYPERTENSIVE ARTERIOSCLEROTIC years			
DUE TO (c)		CARDIOVASCULAR DISEASE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) Frederick (State) Md.					
21. I certify that (I) (this hospital) attended the deceased from 10/20 1961 to 10/21 1961 , that (I) (we) last saw the deceased alive on 10/20 1961 , and that death occurred at 2 PM , from the causes and on the date stated above.					
22a. SIGNATURE Richard C. Reynolds		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10/21/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 9 EAST CHURCH ST. FREDERICK, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/23/61		23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE	
24. FUNERAL DIRECTOR'S SIGNATURE L. J. Ruck 5305 HARFORD Rd.		ADDRESS		25a. REC'D BY REGISTRAR DATE 24 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11399

Item 14 in m G-999

CERTIFICATE OF DEATH

11385

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural Emmitsburg

c. LENGTH OF STAY IN 1b

50 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Oct. 25. 1961

19

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED DIVORCED

April 20. 1878

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Professor

Mt. St. Marys College-Ireland Tipperary Co. U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

James Norris

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

217-30-5759

Lumen F. Norris Emmitsburg

Md

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

720.1 DUE TO

Conditions, if any, wh.ch
gave rise to immediate cause
(a), stating the underlying
cause last. (b)

DUE TO

(c)

Coronary occlusion

arteriosclerosis

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year:
Hour a.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town)
p.m. 19 While Not While factory, street, office bldg., etc.) (County) (State)21. I certify that (I) (this hospital) attended the deceased from Nov. 1959 to Oct. 25, 1961, that (I) (we) last
saw the deceased alive on Oct. 24, 1961, and that death occurred 6:15A.M. from the causes and on the date stated above.

22a. SIGNATURE

George L. Morningstar

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

George L. Morningstar

22d. ADDRESS

S. Seton St. Emmitsburg MD
23d. LOCATION (City, town or county) (State)23a. BURIAL, CREMATION, 23b. DATE THEREOF
REMOVAL (Specify)

23c. NAME OF CEMETERY OR CREMATORI

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Burial Oct. 27. 1961 St. Anthony Cem.

Thurmont, Md.

DATE OCT 31 '61

Arthur S. Haas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
15M 9/60

TO **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Please sign and completely fill in by the funeral director.

TO **BURIAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11400 11386

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>	
3. NAME OF DECEASED (Type or print) <i>CURTIS</i>		First <i>OMER</i>	Middle <i>OTHEY</i>
4. DATE OF DEATH <i>Oct. 13</i>		Month <i>OCT.</i>	Day <i>13</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Sept. 30 1901</i>		9. AGE (In years last birthday) <i>60 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>J. P. Printing Co.</i>	10c. BIRTHPLACE (State or foreign country) <i>Woodlawn, Va.</i>
11. FATHER'S NAME <i>Linwood C. Othey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Kingson</i>	15. SOCIAL SECURITY NO. <i>218-05-2889</i>
16. INFORMANT <i>Mrs. Mary C. Othey</i>		17. INFORMANT <i>Same address</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive aspiration pneumonia</i>
19. MEDICAL CERTIFICATION DUE TO <i>111X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>Frederick, Maryland</i>		(County) <i>Maryland</i>	(State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>10/12</i> to <i>10/13</i> 1961, that (I) (we) last saw the deceased alive on <i>10/13</i> 1961, and that death occurred at <i>9A</i> M. from the causes and on the date stated above.		22b. DATE SIGNED	
22c. SIGNATURE <i>Thomas J. Michael</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>Frederick, Maryland</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct. 18, 61</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Evergreen Memorial Gardens, Westminster, Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers, Jr., Westminster, Md.</i>		25a. ADDRESS <i>ADDRESS</i>	25b. REC'D BY REGISTRAR <i>REC'D OCT 19 '61</i>
		25c. REGISTRAR'S SIGNATURE <i>John S. Moore</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11357

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 2 yrs		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 21A West All Saints St		d. STREET ADDRESS 21A West All Saints St	
3. NAME OF DECEASED (Type or print) Mary Ambush		4. DATE OF DEATH 10 11 19 61	
5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 50-10-1901 60 yrs.		9. AGE (In years last birthday) 10 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. US J.A. OCCUPATION (Give kind of work done during most of working life, even if retired) hotel maid		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland U.S.A.	
13. FATHER'S NAME Earnest Ambush		12. CITIZEN OF WHAT COUNTRY? Johnnie Williams Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT UNKNOWN	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Death - Probable CORONARY THROMBOSIS DUE TO Condition (b) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE 4+ years which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, e) Rheumatoid Arthritis; Spastic Paraplegia, mild.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 1b.)	
20c. TIME OF INJURY Hour e.m. Month, Day, Year p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 10/2/1961, and that death occurred at 10 AM, from the causes and on the date stated above.		22. SIGNATURE Richard C. Reynolds, M.D.	
22c. PHYSICIAN'S NAME (Type) RICHARD C. REYNOLDS, M.D.		22d. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22e. ADDRESS 9 EAST CHURCH ST. FREDERICK, MD	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 10-14-61		23c. NAME OF CEMETERY OR CREMATORIAL St Pauls	
24. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks III ADDRESS Hicks Funeral Home		23d. LOCATION (City, town or county) Della, Frederick Co., Md (State)	
25a. REC'D BY REGISTRAR DET 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after it is filed with the hospital or attending physician.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11402

CERTIFICATE OF DEATH

Reg. Dist. No. 11388

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN lb

—

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

Maryland

b. COUNTY

Carroll

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

En Route to Hospital in Ambulance

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Mt. Airy

06x-2

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Dec 23, 1874

9. AGE (In years
last birthday)

86 yrs

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

Farm

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

George Washington Rigler

14. MOTHER'S MAIDEN NAME

Elizabeth Elgin

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

INFORMANT

Mrs. Hattie Rigler, Mt. Airy, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)+
Conditions, if any, which
gave rise to immediate
cause (a), stating the under
lying cause last.

DUE TO

(b)

DUE TO

(c)

Acute Coronary Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

1 hr.

Arteriosclerotic Cardiovascular Disease

10 years.

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County)

(State)

21. I certify that I attended the deceased from _____, 19____, to October 12, 1961, that I last saw the deceased alive on October 12, 1961, and that death occurred at 5 p.m., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

W.B. Culwell

M.D.

900 San Marin St.

10/13/61

PHYSICIAN'S
NAME (Type)

W.B. Culwell

Mt. Airy, Md.

22a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

22b. DATE THEREOF

10-15-1961

22c. NAME OF CEMETERY OR CEMATORIAL

Pine Grove Cemetery

22d. LOCATION (City, town, or county)

Mt. Airy, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

C. M. Waltz, Winfield, Maryland

ADDRESS

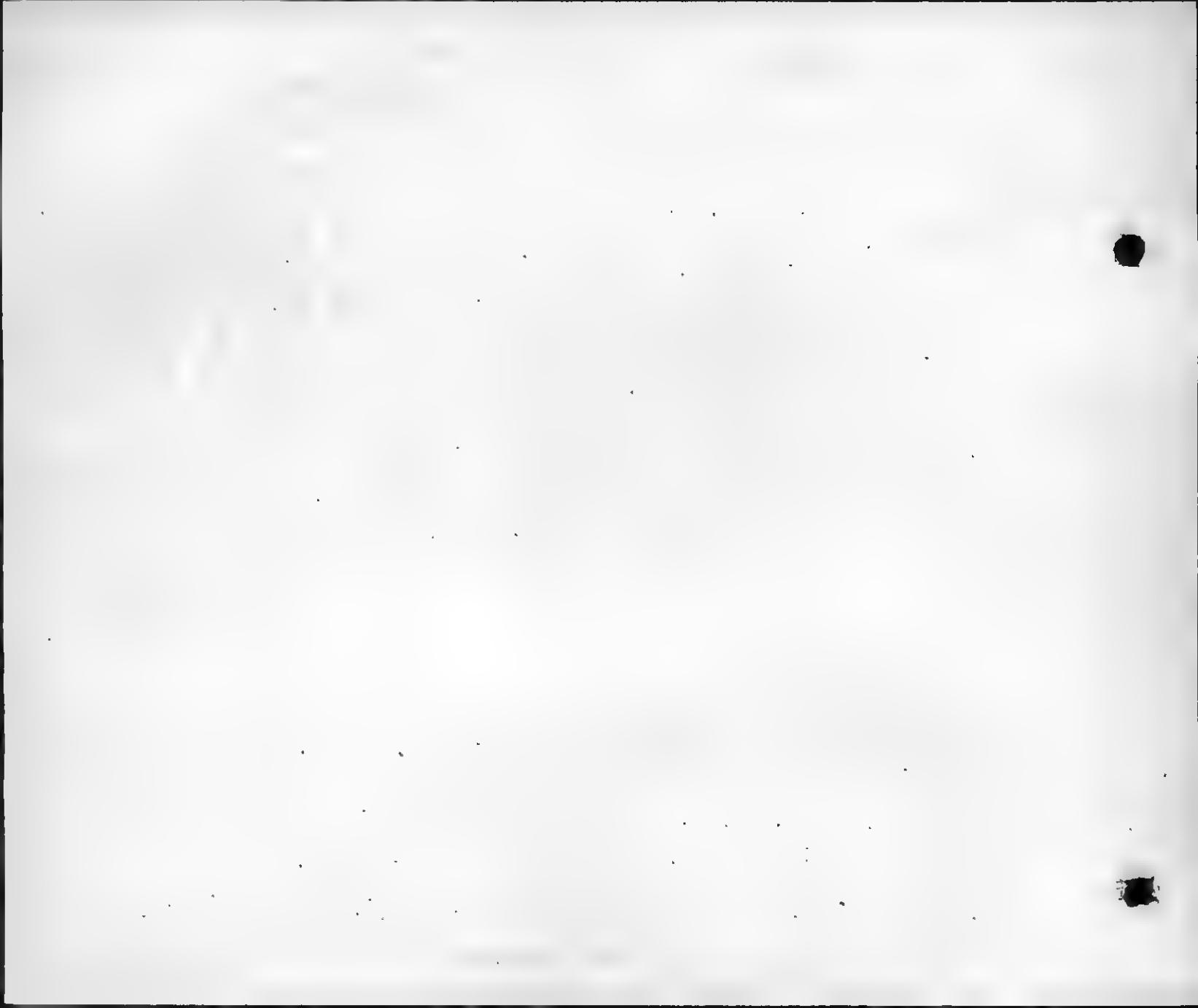
Winfield, Maryland

24a. REC'D BY REGISTRAR

OCT 17 '61

24b. REGISTRAR'S SIGNATURE

John S. Thomas



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

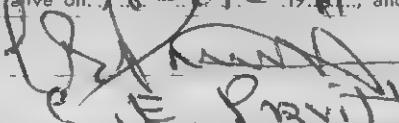
11386

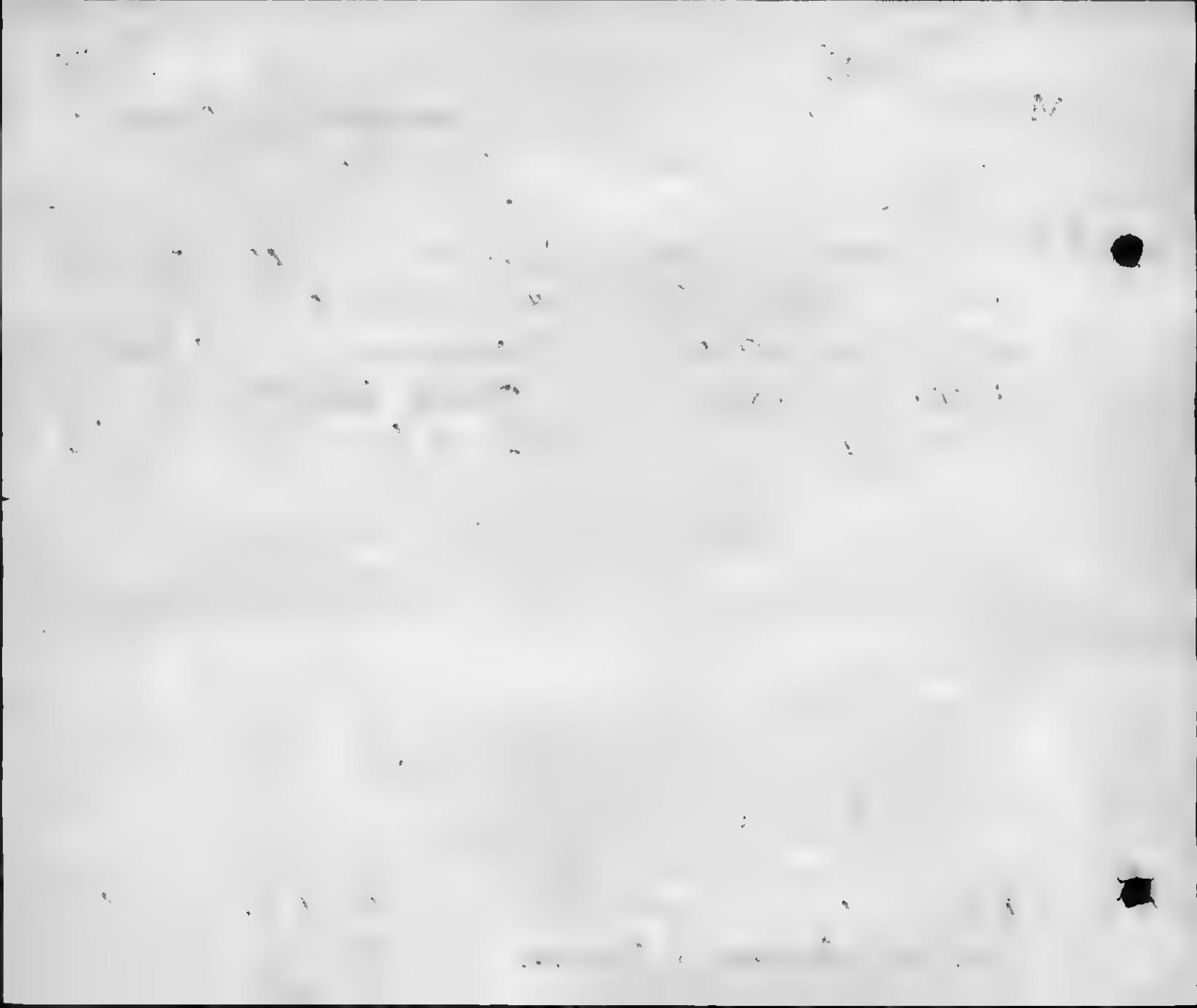
11403

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission) b. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRUNSWICK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRUNSWICK	
c. LENGTH OF STAY IN 1B 65 YRS.		d. STREET ADDRESS 220 A STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 220 A STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES First HENRY Middle RINKER Last		4. DATE OF DEATH Month 10 Day 29 Year 1961	
5. SEX MALE 6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED 4-19-1896	
9. AGE (in years, less birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PRINTER & PUBLISHER		11. BIRTHPLACE County & State, or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME KIRBY G. RINKER	
14. MOTHER'S MAIDEN NAME FANNIE WENNER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Type or print, and dates of service) WORLD WAR I	
16. SOCIAL SECURITY NO.		17. INFORMANT MRS LOVELLA RINKER, BRUNSWICK, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. Hypertension DUE TO (c)		Address Coronary Occlusion C-V-R disease INTERVAL BETWEEN ONSET AND DEATH 16 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-29-1961 to 10-29-1961 that (I) (we) last saw the deceased alive on 10-29-1961 , and that death occurred at 10 AM , from the causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 10-30-61	
22c. PHYSICIAN'S NAME (Type) E. Privit		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-1-61	
23c. NAME OF CEMETERY OR CREMATORIAL CHURCH OF GOD		23d. LOCATION (City, town or county) Locust Valley Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Thomas		25a. ADDRESS ADDRESS	
25b. REC'D BY REGISTRAR NOV 3 '61		25c. REGISTRAR'S SIGNATURE Arthur S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11404

CERTIFICATE OF DEATH

Reg. Dist. No. 11390

M
PLACE OF DEATH
O. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural—Mt. Airy

c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

R. D. # 4

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

Maryland

b. COUNTY

Frederick

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural—Mt. Airy

d. STREET ADDRESS

R. D. # 4

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

October 17,

1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Aug. 7, 1897

9. AGE (in years
(at birthday)
yrs.)

64

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

Year

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Merchant

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Z. Rippeon

14. MOTHER'S MAIDEN NAME

Ida M. Zimmerman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

220-16-4153

17. INFORMANT

Mrs. Hilda E. Rippeon, Same as # 2

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1930

Cerebral Tumor (Malignant)

INTERVAL BETWEEN
ONSET AND DEATH

1 yr

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Sept. 1961, to Oct. 17, 1961, that I last saw the deceased alive on Oct. 16, 1961, and that death occurred at 6 a. M., from the causes and on the date stated above.

ACTUAL
SIGNATURE

C. M. Van Poole, M. D.

ADDRESS (Street, city or town, state)

DATE SIGNED

10-17-61

PHYSICIAN'S
NAME (Type)

C. M. Van Poole, M. D.

Mt. Airy, Maryland

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

10-20-1961

22c. NAME OF CEMETERY OR CREMATORI

Locust Grove Cemetery Frederick Co., Maryland

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

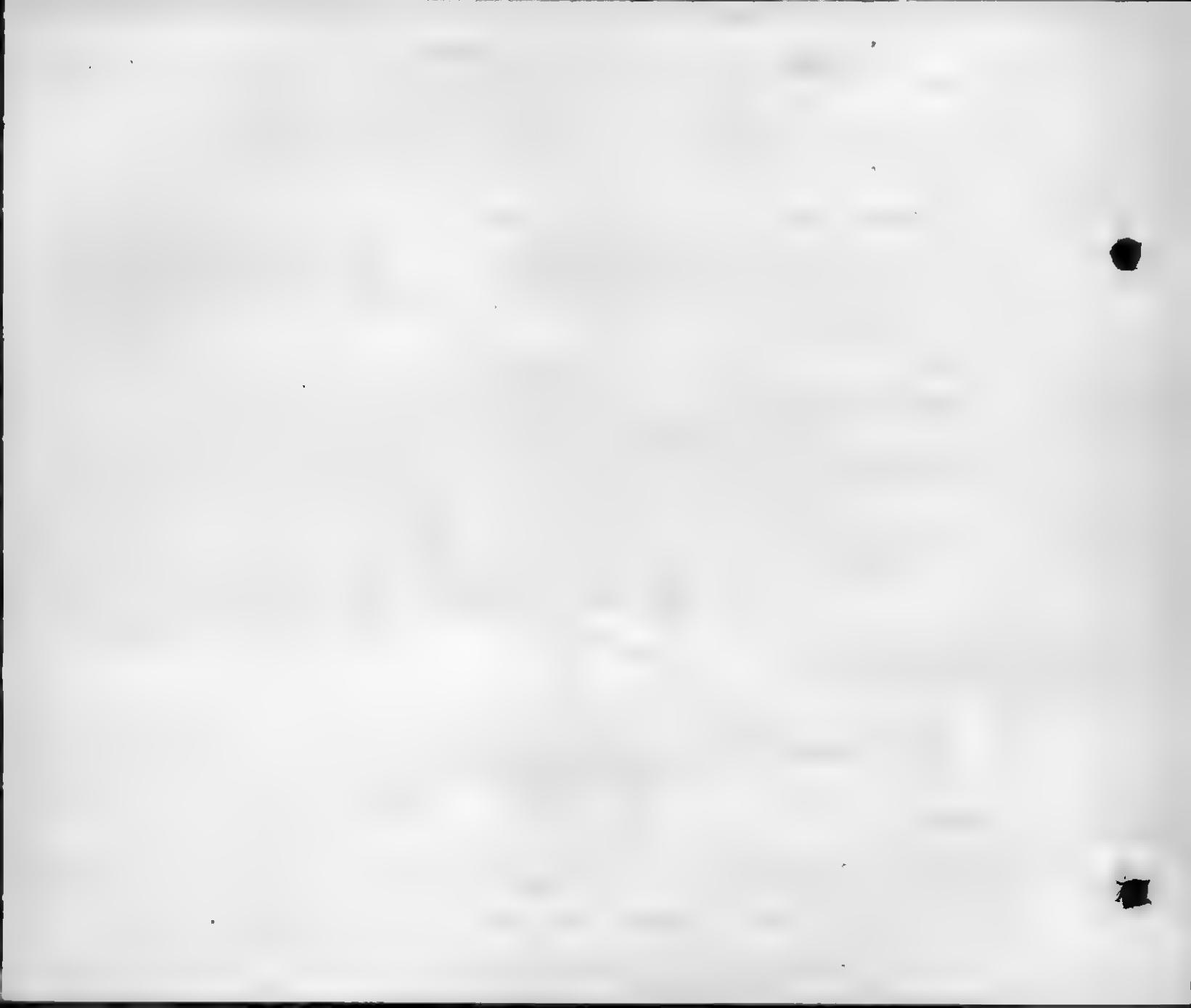
C. M. Waltz, Winfield, Maryland

24a. REC'D BY REGISTRAR

OCT 18 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kline



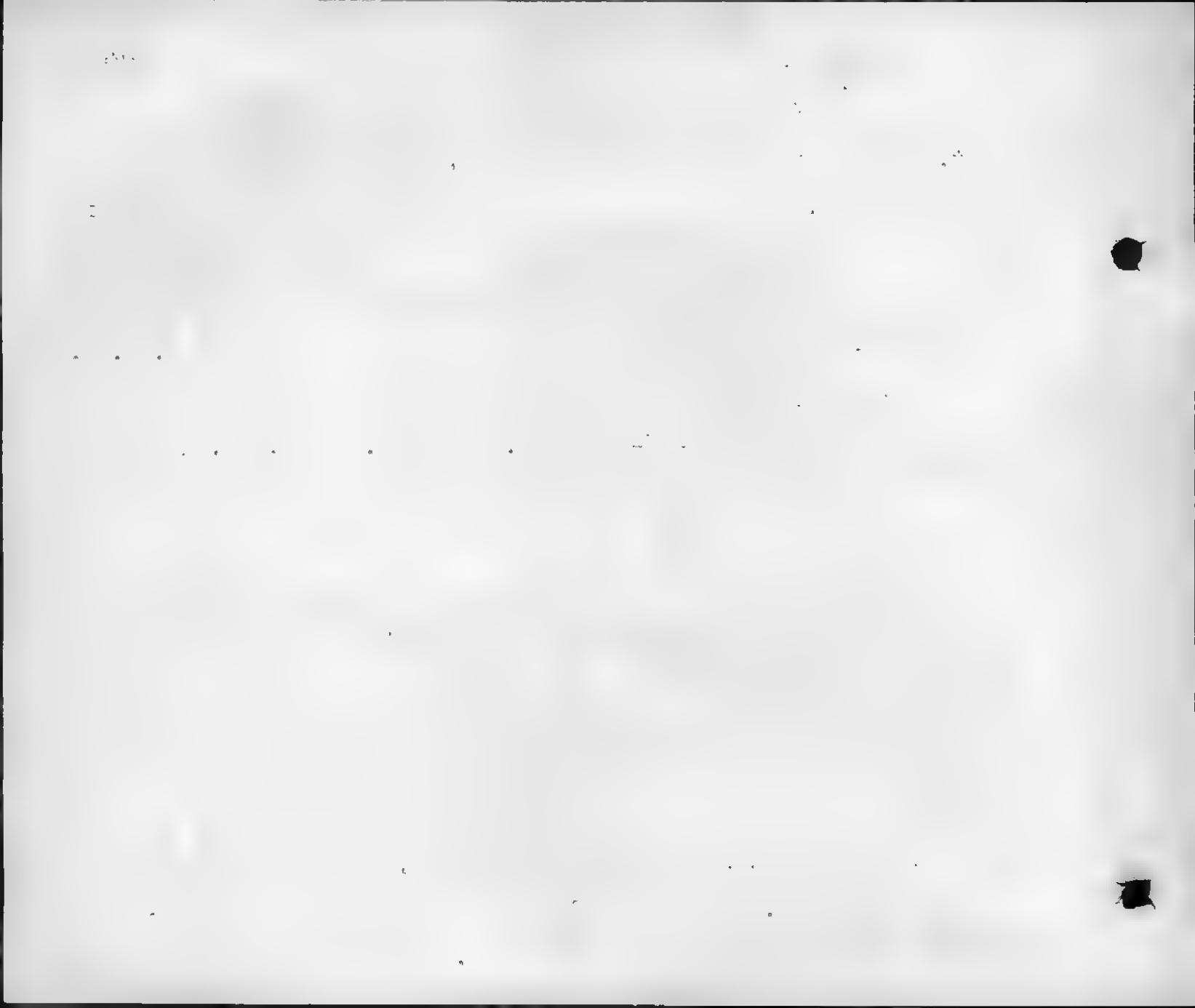
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11405 CERTIFICATE OF DEATH 11391

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy Route 4		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Linganore		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANK MCKINLEY ROHRBACK		First	Middle
4. DATE OF DEATH Oct. 21 1961		Month	Day
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 18 April 1896
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) farmer-retired		10b. KIND OF BUSINESS OR INDUSTRY owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin Rohrback		14. MOTHER'S MAIDEN NAME Lydia Cochran	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 213-36-7786 Mrs. Nellie G. Young, Mt. Airy Route 4	
17. INFORMANT		Address Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a)) 16-X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Carcinoma of Lungs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Extensive metastatic carcinoma of liver, inanition.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1961 19 to 10/21/61 19, that (I) (we) last saw the deceased alive on 10/20/61 19, and that death occurred 10/21/61 from the causes and on the date stated above		22b. DATE SIGNED 10/21/61	
22a. SIGNATURE <i>G.F. Meadows, M.D.</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) G.F. Meadows, M.D.		22d. ADDRESS Damascus, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 23 Oct. 1961 Central Cemetery	
23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town, or county) Frederick County, Maryland (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>D.L. Hartblad, Jr.</i>		ADDRESS Libertytown, Md.	
		25a. REC'D BY REGISTRAR DATE OCT 24 '61	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



14
11406
11392

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **Page 1** is to be retained by the hospital or attending physician and completely filled in by the funeral director. **Page 2** should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, **page 3** should be detached for use as the burial-transit permit. Then please remove carbon papers. **Page 1** and **2** should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
FREDERICK MARYLAND		MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b RURAL 58 YRS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1 R.F.D 2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print)		First	Middle
Howard		13	Smith
4. DATE OF DEATH		Month	Day
Oct 9		1961	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
MALE		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (in years lost birthday)	10. IF UNDER 1 YEAR
Aug 9, 1903		58 yrs	IF UNDER 24 HRS
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
U.S.		A. B. Smith	Frances Moxley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
No		218-30-9139	A. B. Smith
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Address	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
260X		Cardiac occlusion	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (If either, notify medical examiner)		10 months	
DUE TO		Heart Block	
(b)		4 months	
DUE TO		Droctocosis mellitus	
(c)		3 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 15, 1961</u> to <u>Oct 9, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct. 1, 1961</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE		M D ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
B. Thompson		Oct. 12, 1961	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
B. Thompson, MD		Frederick, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		Oct. 12, 1961	
23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town, or county) (State)	
1st. Civ. Cem.		Frederick, Md	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
B. Thompson		Frederick, Md	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
OCT 16 '61		Walter S. Keane	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11393

M

11407

I

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 19 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First James	Middle LESTER	Last Smith
4. DATE OF DEATH	Month October	Day 15, 1961	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sexton	10b. KIND OF BUSINESS OR INDUSTRY Hood College	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James C. Smith		14. MOTHER'S MAIDEN NAME Mary Geisbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO 220-18-1799	17. INFORMANT Mrs. Mary J. Smith (Same as item #2)	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 4211 DUE TO Uremia		INTERVAL BETWEEN ONSET AND DEATH None Days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Uremia (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) affrolectomy 10/7/61 for enlarged affroly			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) affrolectomy 10/7/61 for enlarged affroly		
20c. TIME OF INJURY Hour a. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/17/1961 to 10/15/1961 , that (I) (we) last saw the deceased alive on 10/15/1961 , and that death occurred 10/15/1961 M, from the causes and on the date stated above.			
22a. SIGNATURE Robert S. Pilgrim	M.D.	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 16 Oct 1961
22c. PHYSICIAN'S NAME (Type) Robert S. Pilgrim	22d. ADDRESS Prof. Bldg, Frederick		
23a. BURIAL, Cremat., REMOVAL (Specify) Burial	23b. DATE THEREOF 10-19-1961	23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	23d. LOCATION (City, town, or county) (State) Frederick Maryland
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison and Son, Frederick, Maryland	ADDRESS	25a. REC'D BY REGISTRAR C. Etchison	25b. REGISTRAR'S SIGNATURE Calvin S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11408

11394

1. PLACE OF DEATH

a. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bartonsville Rt 6

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Bartonsville Rt 6

3. NAME OF DECEASED

(Type or print)

Harry

First

Middle

Last

Snowden

5. SEX

Male

negro

WIDOWED

DIVORCED

7. MARRIED NEVER MARRIED 8. DATE OF BIRTH

7-11-1890

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

laborer

13. FATHER'S NAME

Greenberry Snowden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

4-0-0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)

DUE TO

(c)

16. SOCIAL SECURITY NO. 17. INFORMANT

unknown

Ida Brown

122 East St Frederick, Md

Address

INTERVAL BETWEEN ONSET AND DEATH

1 HR

CORONARY ARTERY THROMBOSIS

ARTEROSCLEROTIC HEART DISEASE

GENERALIZED ARTEROSCLEROSIS

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 1920d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from FEB. 26, 1961, to OCT. 28, 1961, that (I) (we) last saw the deceased alive on OCT. 28, 1961, and that death occurred at... M, from the causes and on the date stated above

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 10-31-61

23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

Bartonsville

3RD ST FREDERICK, MD

22b. DATE SIGNED

24. FUNERAL DIRECTOR'S SIGNATURE

C.E. Hicks 111

Frederick, Md

23d. LOCATION (City, town or county) (State)

Bartonsville, F red co, Md

DATE NOV 2 '61

CHALMERS S. HICKS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11408

15M 9/60

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

Page 4 may be retained by the hospital or attending physician.
TOMB FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and notarized, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11409

11395

1. PLACE OF DEATH

a. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Thurmont

MARYLAND

c. LENGTH OF STAY IN lb

50 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

At Home

3. NAME OF
DECEASED
(Type or print)

ESTHER

FLORENCE

STITELY

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

WIDOWED

DIVORCED

Dec. 3. 1896

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Frederick Co. MD

13. FATHER'S NAME

John Carty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

220-03-2212

Mrs. Madeline Lewis

Thurmont, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

1201
DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Acute myocardial infarction

Atherosclerosis

INTERVAL BETWEEN
ONSET AND DEATH

2 hours

10 years

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

Arteriosclerotic Cerebral thrombosis ± 4 years previously

19. WAS AUTOPSY
PERFORMED?

YES NO

20e. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item (b).)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 19..... to 10-9-61, 19....., that (I) (we) last saw the deceased alive on 10-9-61, and that death occurred at 10-9-61, from the causes and on the date stated above.

22a. NATURE

22c. PHYSICIAN'S
NAME (Type)

Thomas A. Love

ATTENDING
PHYS.

M.D.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

22b. DATE
SIGNED

Thurmont, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 10-12-61

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM
United Brethren Com.

23d. LOCATION (City, town or county) (State)
Thurmont, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

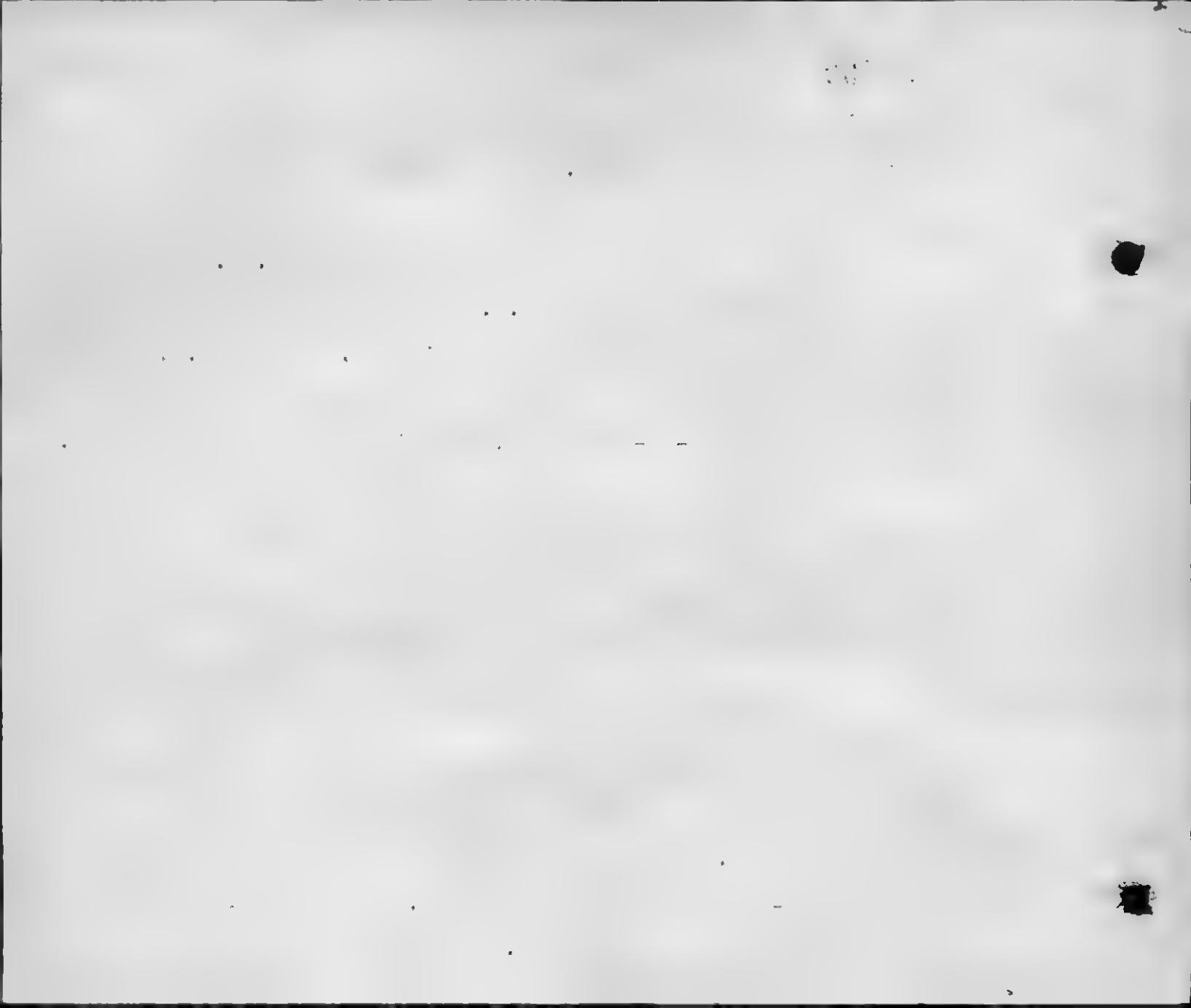
Thurmont, Md.

25e. REC'D BY REGISTRAR

DATE OCT 16 '61

25b. REGISTRAR'S SIGNATURE

Leigh S. Thomas



SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/10

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11396

1. PLACE OF DEATH
a. COUNTY
Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Frederick

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Frederick Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

EDYTH

BOLLING

SUMMERS

5. SEX
Female

6. COLOR OR RACE
White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)
House-work

10b. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (County & State, or foreign country)

Buckeystown, Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Harry D. Shankle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)
No

16. SOCIAL SECURITY NO.

17. INFORMANT

216-09-0041 Hoyt J. Summers (Same as item #2)

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

1810 DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. (b)

DUE TO

(c)

Liver cirrhosis

INTERVAL BETWEEN
ONSET AND DEATH
about 6 years

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Nov 1, 1957 to Oct 26, 1961, that (I) (we) last
saw the deceased alive on Oct 25, 1961, and that death occurred at 12:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE

22e. PHYSICIAN'S
NAME (Type)

E. A. Dettbarn, M. D.

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
29 Oct 1961

22d. ADDRESS

Walkersville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 23b. DATE THEREOF
10-31-61

23c. NAME OF CEMETERY OR CREMATORIUM
Mount Olivet Cemetery

23d. LOCATION (City, town or county)

Frederick, Maryland

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

M. R. ETCHEISON & SONS

Frank A. Smith

ADDRESS

Frederick, Md.

25e. REC'D BY REGISTRAR

DATE NOV 1 '61

25b. REGISTRAR'S SIGNATURE

Orlney S. Keans

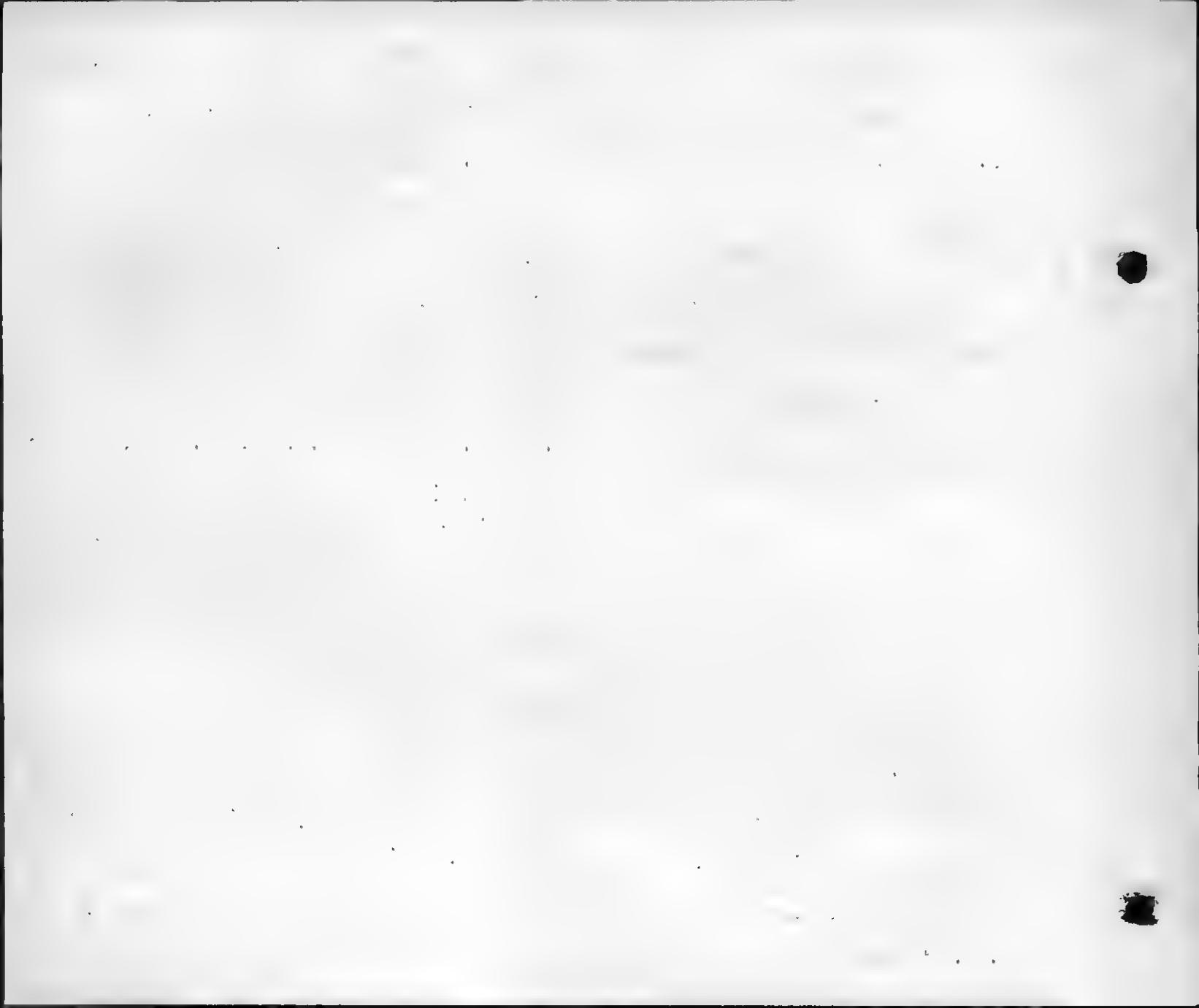


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

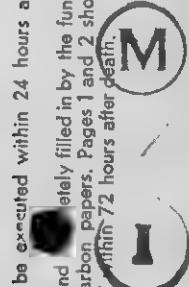
Reg. Dist. No. 11397

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy Rural #1		c. LENGTH OF STAY IN 1b 26 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lime Plant Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy Rural #1	
d. STREET ADDRESS Lime Plant Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First FERDINAND	Middle	Last THOMPSON
4. DATE OF DEATH	Month October	Day 16	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH January 31, 1871
8. AGE (In years last birthday) 90	9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS Days 0	11. Hrs 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tenant Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John W. Thompson	14. MOTHER'S MAIDEN NAME Mary Mahoney		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	INFORMANT Mr. Roy J. Thompson, R.D. #1, Mt. Airy, Maryland	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure with DUE TO Pulmonary Edema - Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b) Arterio Sclerotic Heart Disease DUE TO Several years (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year
20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Monrovia	(County) 900 So. Main St.
21. I certify that I attended the deceased from 1956 , to Oct. , 1961, that I last saw the deceased alive on October 16, 1961 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.B. Culwell		ADDRESS (Street, city or town, state) 900 So. Main St. Mt. Airy, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-20-1961	22c. NAME OF CEMETERY OR CREMATORIUM Bush Creek Cemetery
22d. LOCATION (City, town, or county) Monrovia		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison and Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE OCT 19 '61	24b. REGISTRAR'S SIGNATURE Cirrus S. Francis



1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



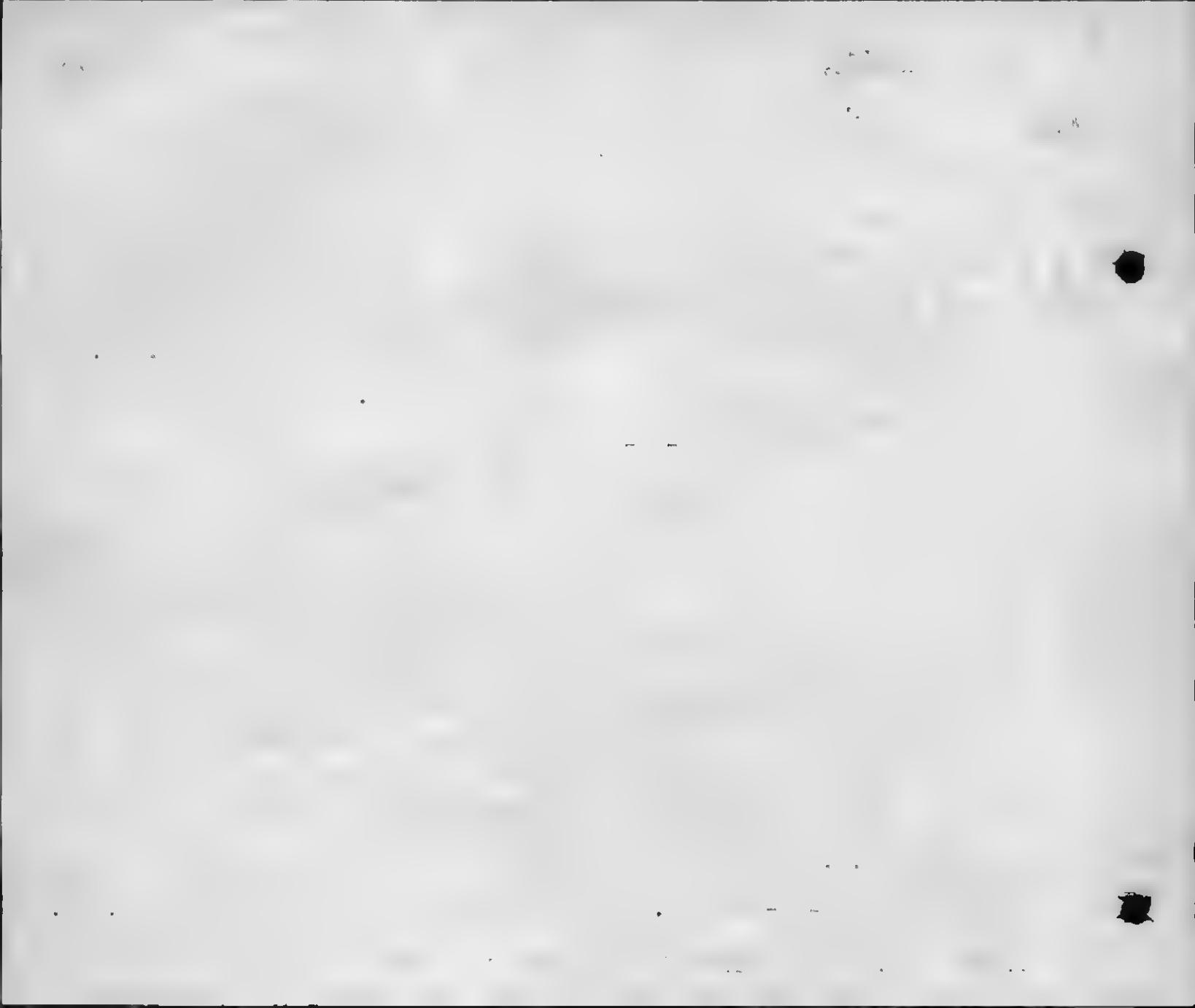
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11412

11398

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		EMMITSBURG rural		a. STATE Maryland	
c. LENGTH OF STAY IN 16		Lifetime		b. COUNTY Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Own Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
EMORY		ERNEST	VALENTINE		Month
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months
male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> March 3, 1891	70 yrs.	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
Farmer		Own Farm		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY	
Elmer Valentine		Helen M. Ohler		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address	
NO		215-34-3966			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma prostate c metastases</i>					
177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20d. DESCRI BE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19					
21. I certify that (I) (this hospital) attended the deceased from <i>Jul 1 1955</i> to <i>Oct 16 1961</i> , that (I) (we) last saw the deceased alive on <i>Oct 15 1961</i> , and that death occurred at <i>8:15 A.M.</i> from the causes and on the date stated above.					
22e. SIGNATURE <i>W.R. Cadle</i>		M.D.		22b. DATE SIGNED <i>Oct 19 61</i>	
22c. PHYSICIAN'S NAME (Type) W.R. Cadle		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS Emmitsburg, Maryland		22d. ADDRESS			
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-61		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Tabor Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond S. Creager</i>		ADDRESS Thurmont, Md.		25e. REC'D BY REGISTRAR DATE OCT 19 '61	
				25b. REGISTRAR'S SIGNATURE <i>Albert S. Kraus</i>	

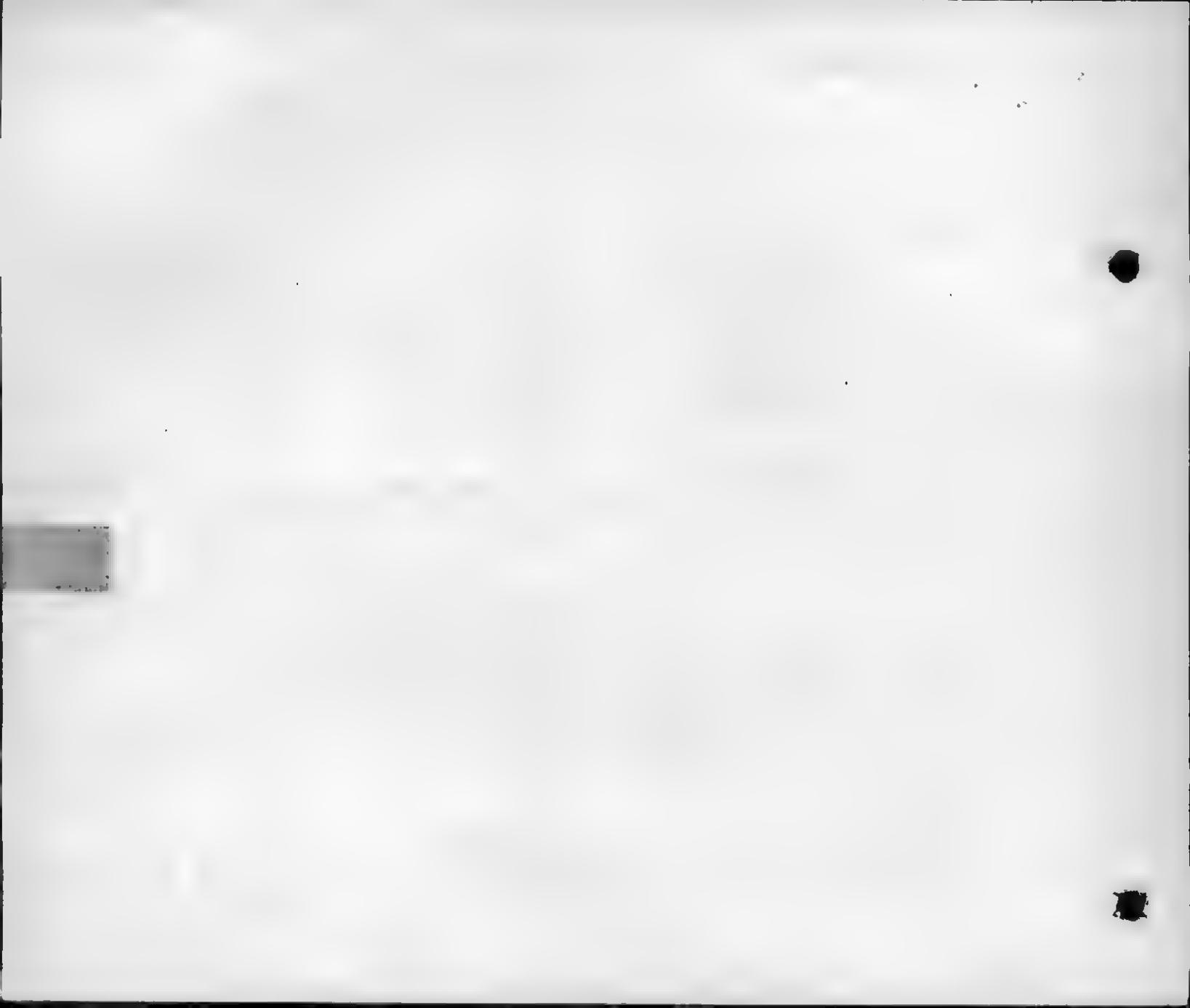


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11413 11399

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. LENGTH OF STAY IN 1b 2723 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Holly D		4. DATE OF DEATH Month 10 Day 17 Year 1961	
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10-8-1897	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Golf teacher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) W. Va		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew M. Vaughan		14. MOTHER'S MAIDEN NAME J. Elizabeth George	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 233-12-8369	
17. INFORMANT Record of Victor Cullen State Hosp.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis - 002 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Arteriosclerotic Heart Disease - 420		20f. (City or town) (County) (State) 5/4 1961, to 10/17 1961	
21. I certify that (I) (this hospital) attended the deceased from 10/16 1961 and that death occurred at 7:30 AM , from the causes and on the date stated above.		22. MEDICAL CERTIFICATION 22a. SIGNATURE Michael S. Zavis	
22c. PHYSICIAN'S NAME (Type) Michael S. Zavis		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Cullen, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 19-1961	
23c. NAME OF CEMETERY OR CRYPTORY Willcrest Cemetery		23d. LOCATION (City, town, or county) (State) Bethesda, Md. 20901	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Prague, Thurmont, Md.		25a. REC'D BY REGISTRAR DA 19 '61	
ADDRESS 11413		25b. REGISTRAR'S SIGNATURE Michael S. Zavis	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11414

CERTIFICATE OF DEATH

11400

1. PLACE OF DEATH

6. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Sunnyside

8. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Sunnyside, Rt 4

3. NAME OF
DECEASED
(Type or print)

First

Middle

Bertha

Mae

Weedon

5. SEX

6. COLOR OR RACE

Female

negro

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Midwife

7. MARRIED NEVER MARRIED

b. DATE OF BIRTH

WIDOWED DIVORCED

5-8-1883

13. FATHER'S NAME

Charles Bowens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give rank or grade or service no.

no

16. SOCIAL SECURITY NO.

17. INFORMANT

none

Howard M. Weedon

Address

Frederick, Co

Rt 4 Sunnyside

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.

DUE TO

(b)

DUE TO

(c)

Chronic congestive heart failure
Arteriosclerotic heart diseaseINTERVAL BETWEEN
ONSET AND DEATH

Month

Year

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1959 to 10/27, 1961, that (I) (we) last saw the deceased alive on 10/25, 1961, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

James B. Thomas

23a. BURIAL, CREMATION, REMOVAL
(Specify)

Burial 10-30-61

23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

Sunnyside

M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.
22d. ADDRESS

22b. DATE SIGNED

24. FUNERAL DIRECTOR'S SIGNATURE

C. E. Hicks III

23d. LOCATION (City, town or county) (State)

Frederick Maryland

25a. REC'D BY REGISTRAR DATE

NOV 2 '61

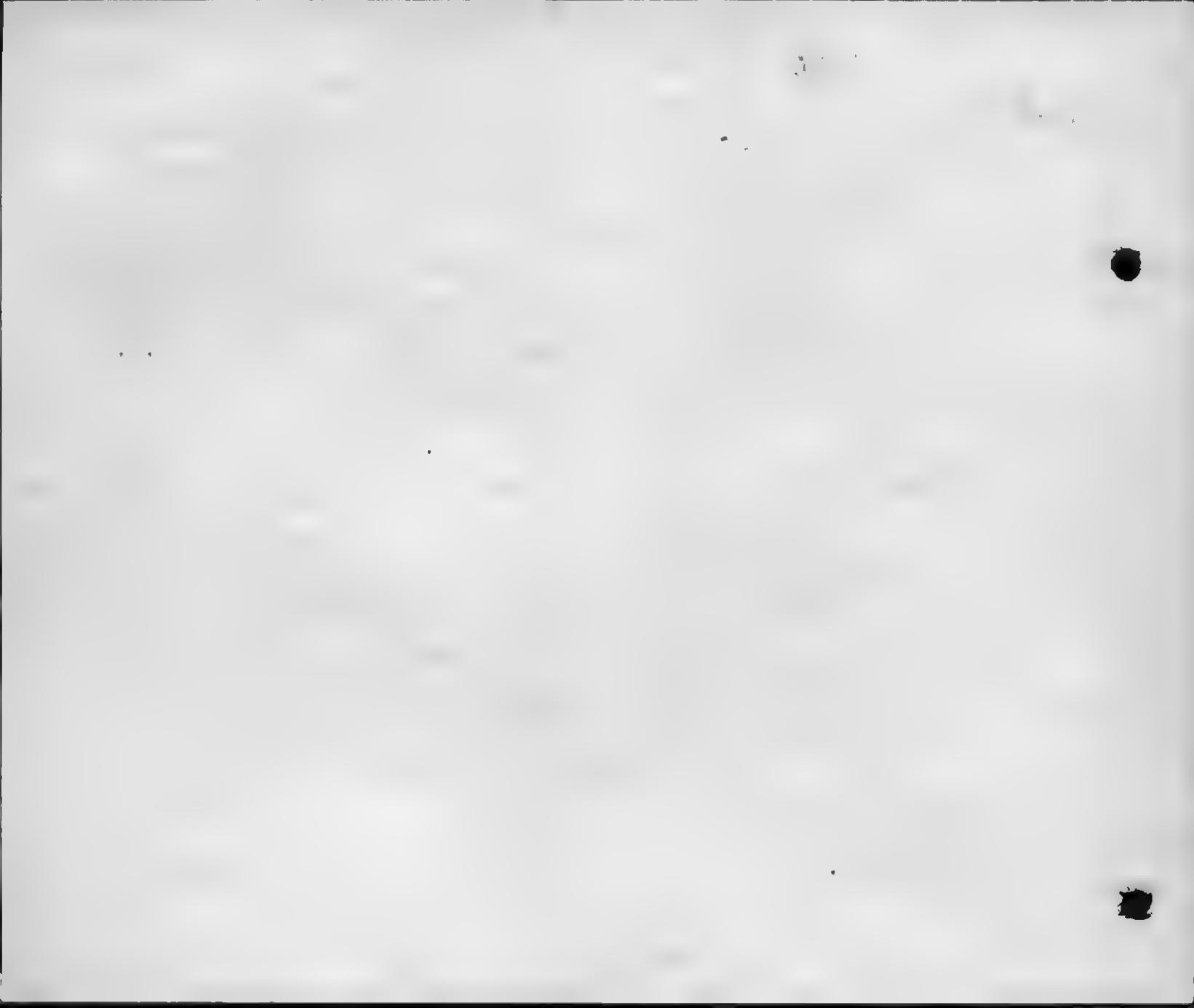
Arthur S. Kraus

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after page 4 may be retained by the hospital or attending physician.

Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4

VR A15 (4)
15M 9/60



1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

the funeral. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and delivered to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11415

CERTIFICATE OF DEATH

11401

1. PLACE OF DEATH
a. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Thurmont

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

I Park Lane

MARYLAND

c. LENGTH OF STAY IN HOSPITAL

1 yr

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

b. COUNTY

Md

Frederick

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

X Thurmont

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

WILLIAM

First

Middle

Last

JOSEPH

WILSON

4. DATE
OF
DEATH

Oct. 19. 1961

Month
Dey
Year

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

April 14, 1886

9. AGE (in years
last birthday)

75

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

12. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Maintainance man

10b. KIND OF BUSINESS OR INDUSTRY

Lehigh Cement Co

11. BIRTHPLACE (County & State, or foreign country)

Near Union Bridge, Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

William W. Wilson

Susan Hildebride

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

16. SOCIAL SECURITY NO.

(Yes, no, or unknown) (If yes give war and date of service)

213-03-1097

17. INFORMANT

No

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

(b)

DUE TO

(c)

Chronic thrombosis

ASCVD

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour

a.m.

p.m.

19

20d. INJURY OCCURRED

While
at work Not While
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) attended the deceased from...

saw the deceased alive on Oct. 16, 1961, and that death occurred at 4 P.M., from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

Thomas A. Love

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

X Thurmont, Md

22b. DATE
SIGNED

10/20/61

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

Oct. 22, 1961

Graceham Cem.

etc.

23c. NAME OF CEMETERY OR CREMATORIUM

Graceham Cem.

23d. LOCATION (City, town or county)

Graceham Fredk. Co. Md

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Raymond S. Quager

ADDRESS

X Thurmont, Md

25a. REC'D BY REGISTRAR

OCT 23 1961

DATE

25b. REGISTRAR'S SIGNATURE

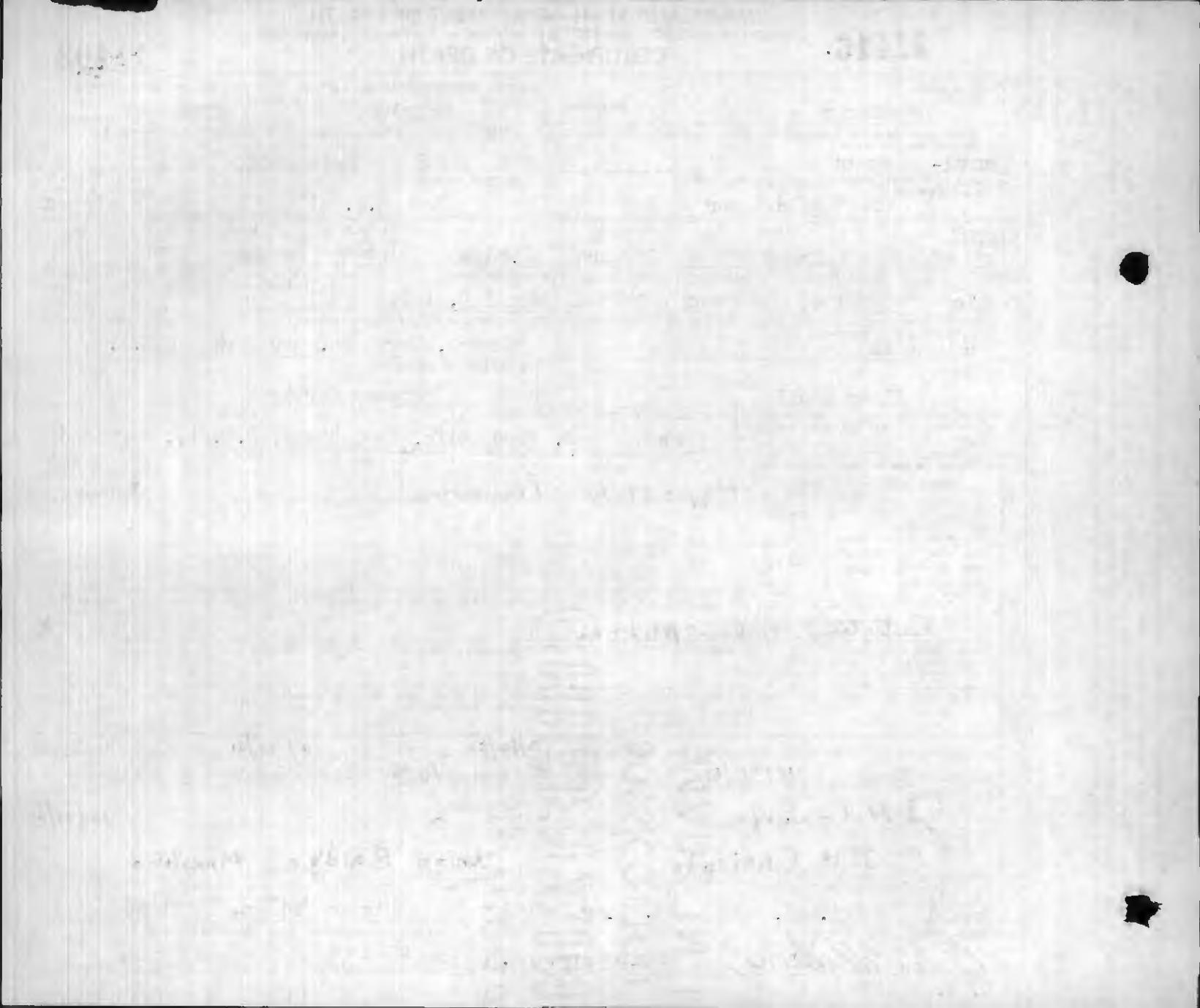
Arthur S. Quager

3.5

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11416		11402	
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Keymar		c. LENGTH OF STAY IN 1b 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brookfield Manor		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Emmitsburg	
f. STREET ADDRESS 1		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
R.D. # 1		h. DATE October 21 1961	
3. NAME OF DECEASED (Type or print) Irene		First Barbara Middle Wolfe Last	
4. DATE OF DEATH October 21 1961		Month Day Year	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1886	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Newark, Wayne Co. New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Stell		14. MOTHER'S MAIDEN NAME Barbara Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT D. Fred Wolfe, Emmitsburg, R.D.#1, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (p) Hypostatic Pneumonia 300.2 DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Catatonic Schizophrenia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/16/61 19 to 10/21/61 19 , that (I) (we) last saw the deceased alive on 10/21/61 19 , and that death occurred 10:55 AM , from the causes and on the date stated above.			
22e. SIGNATURE J. H. Caricofe		22b. DATE SIGNED 10/31/61	
22c. PHYSICIAN'S NAME (Type) J. H. Caricofe		22d. ADDRESS Union Bridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 25, 1961	
23c. NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery		23d. LOCATION (City, town, or county) (State) Union Bridge, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson		ADDRESS Emmitsburg, Md.	
25a. REC'D BY REGISTRAR DATE OCT 24 '61		25b. REGISTRAR'S SIGNATURE John S. Trahan	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11417

11403

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Penna.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Summit</i>		c. LENGTH OF STAY IN 1b <i>11 mos.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Leahart Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>California</i>	
3. NAME OF DECEASED (Type or print) <i>Harold</i>		d. STREET ADDRESS <i>316 Ash. St. 75X-3</i>	
4. SEX <i>Male</i>	5. COLOR OR RACE <i>White</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>10/2/1926</i>
8. DATE OF DEATH <i>Oct. 23 1961</i>	Month <i>Oct.</i>	Day <i>23</i>	Year <i>1961</i>
9. AGE (In years last birthday) <i>35 yrs.</i>	10. IF UNDER 1 YEAR Months <i>—</i>	11. IF UNDER 24 HRS. Days <i>—</i>	12. IF UNDER 24 HRS. Hours <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Penna.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Nicer Young</i>	14. MOTHER'S MAIDEN NAME <i>Anna Shure</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Mr. George Byrne</i>	Address <i>Blue Ridge Summit Pa.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) <i>353.2</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5-6 hrs.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Status convulsivus	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1 Mar 1961</i> to <i>23 Oct 1961</i> that (I) (we) last saw the deceased alive on <i>23 Oct 1961</i> and that death occurred at <i>220A</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Harry H. Young Jr.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>10-23-61</i>
22c. PHYSICIAN'S NAME (Type) <i>HARRY H. YOUNG JR</i>		22d. ADDRESS <i>Blue Ridge Summit, Pa.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>10/24/61</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Holy Society</i>	23d. LOCATION (City, town, or county) (State) <i>Fayette Co. Penna.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Walker Y. Shaw</i>		ADDRESS <i>Waynesboro, Pa.</i>	25a. REC'D BY REGISTRAR DATE <i>OCT 24 '61</i>
			25b. REGISTRAR'S SIGNATURE <i>Arthur S. Tamm</i>

